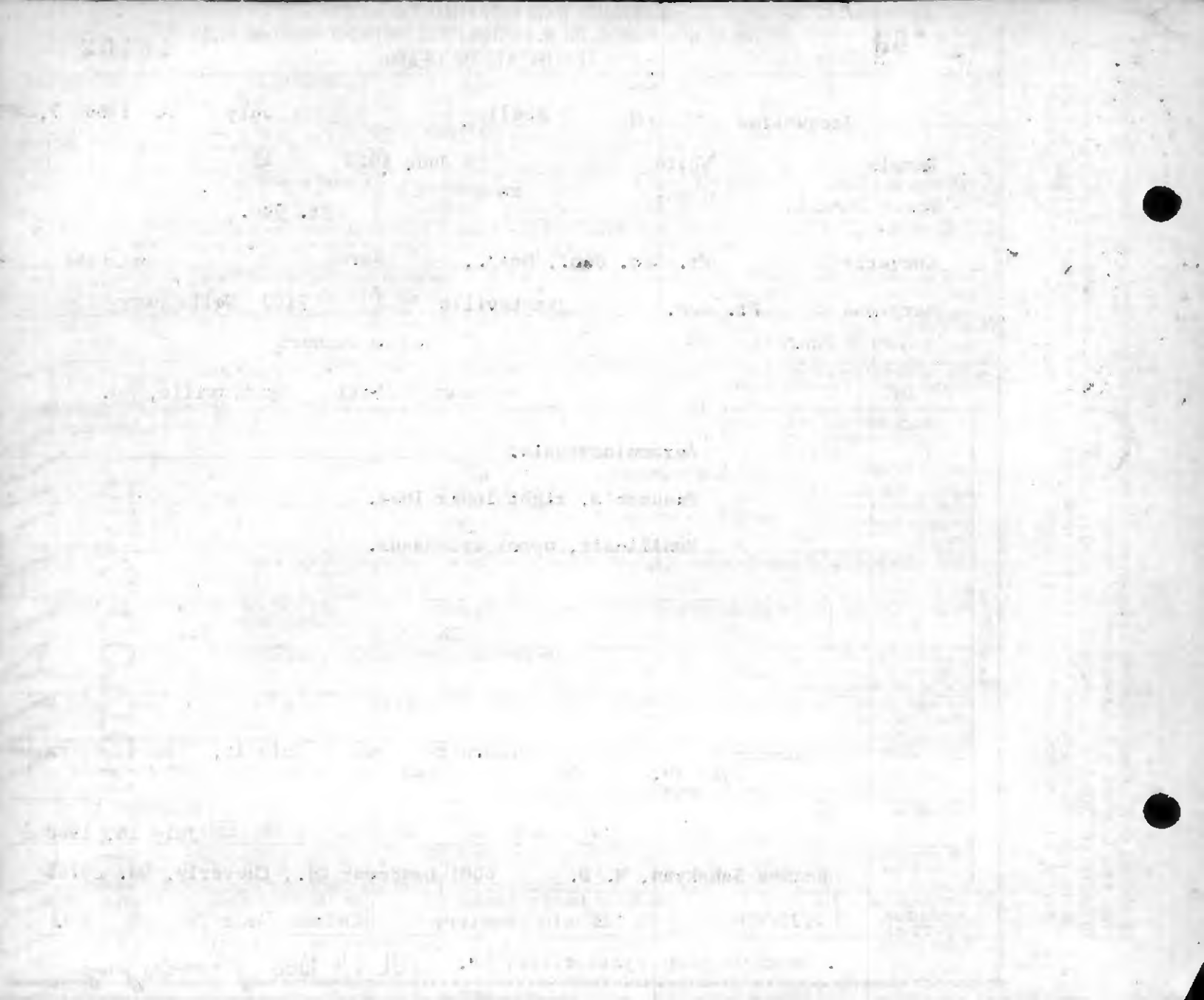


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>Jacqueline M Abell</b>						2a. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>7,20 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9 June 1926</b>		6. AGE (In years last birthday) <b>42</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Pr. Geo.</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo. Gen. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Nurse</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Pr. Geo.</b>			13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>7102 Wells Pkwy</b>	
14. FATHER'S NAME First Middle Last <b>Leo H Hanratty</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Marie Connors</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Dr James E Abell Hyattsville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Agramulocytosis.</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) <b>Pneumonia, right lower lobe.</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <b>Moniliosis, upper esophagus.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
1343											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>February 19 68</b> , to <b>July 16, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>July 16, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(didn't)</del> view the body after death.											
22b. SIGNATURE <b>[Signature]</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>July 16, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Ohannes Sahakyan, M. D.</b>						22e. ADDRESS <b>6001 Landover Rd., Cheverly, Md. 20785</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/19/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>				
24. FUNERAL DIRECTOR <b>F.. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
10394 Item 5 Film 6402 7/10/68 10403  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Royal Leon Allen</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1968</b>			2b. HOUR <b>9:25</b> M.						
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June July 23, 1896</b>		6. AGE (in years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.						
10. CITY OR TOWN OF DEATH <b>Upper Marlboro</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>--</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Carpenter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Pr. Geo County Gov.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo's</b>			13c. CITY OR TOWN <b>Upper Marlboro</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET AND NUMBER <b>--</b>			14. FATHER'S NAME First <b>William L.</b> Middle <b>Allen</b> Last <b>Allen</b>			15. MOTHER'S MAIDEN NAME First <b>Della</b> Middle <b>--</b> Last <b>Snead</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>----</b>			16b. SOCIAL SECURITY NO. <b>214-12-7792</b>			17. INFORMANT Address <b>Same as Item</b> <b>Mrs. George Wesley Allen-#10</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4201</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Cirrhosis</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 1963</b> , to <b>7/1/68</b> , that (I) (we) last saw the deceased alive on <b>7/1/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>A. Clark Holmes M.D.</b>					DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/1/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>A. Clark Holmes, M. D.</b>					22e. ADDRESS <b>Upper Marlboro, Md. 20870</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Upper Marlboro P.G. Md.</b>					
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>					ADDRESS <b>Upper Marlboro, Md.</b>		25a. REC'D BY REGISTRAR <b>WJL - 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

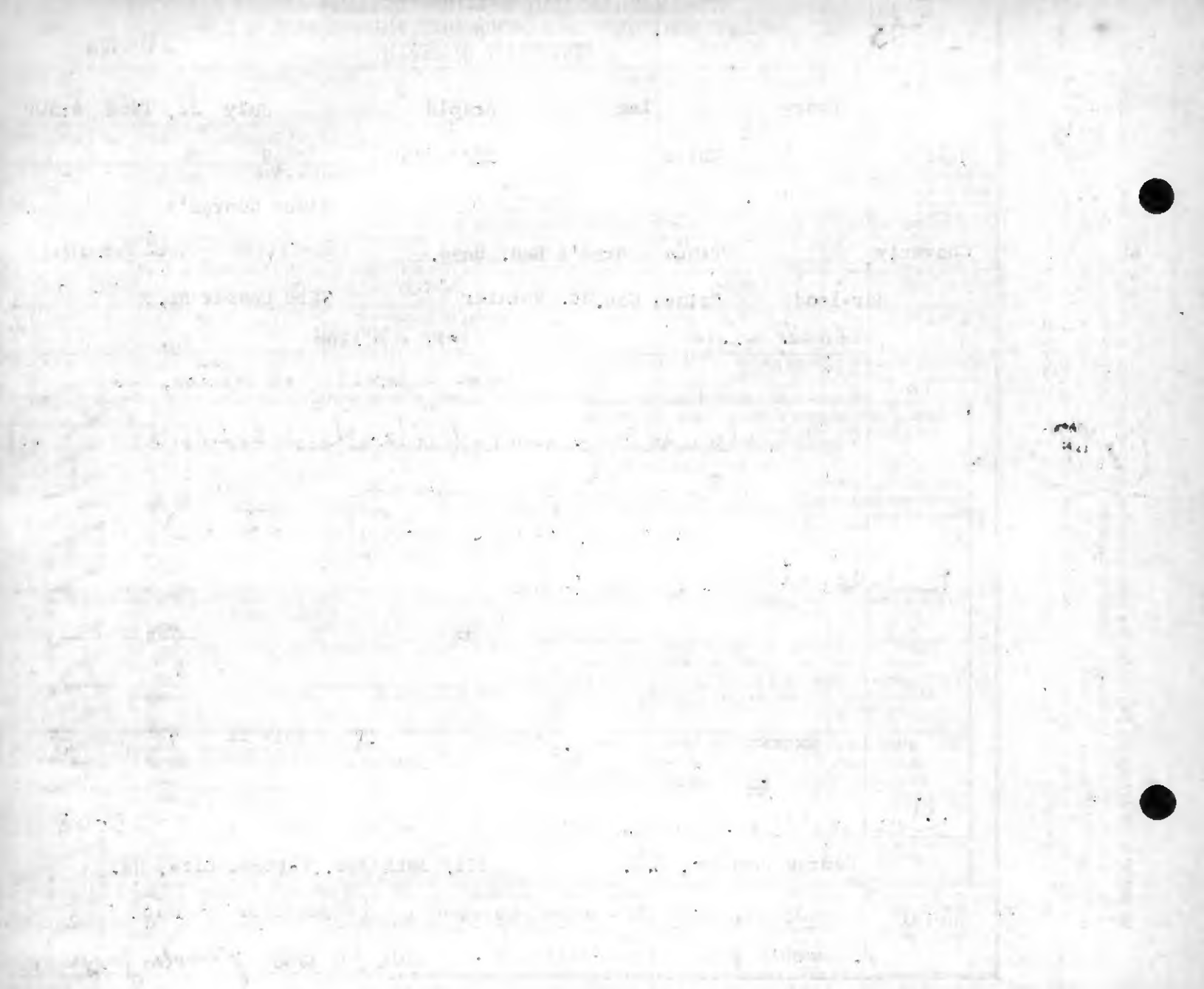




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Henry Lee Arnold						July 22, 1968			4:50p M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		12/19/08		59 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md		U S A				Prince George's		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's Gen. Hosp.			Pipefitter		Wash Terminal	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince Geo. Mt. Rainier					3210 Upshur St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Leister Arnold						Mary E Miller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
no						Violet L Arnold			Mt Rainier, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis (characteristic)</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Bilateral Pul. emboli</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <u>George Hageage, M.D.</u> attended the deceased from <u>7-11</u> , 19 <u>68</u> , to <u>July 22</u> , 19 <u>68</u> , that (I) <u>we</u> lost saw the deceased alive on <u>7-22</u> , 19 <u>68</u> , and that in (my) <u>work</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>did not</u> view the body after death.									
22b. SIGNATURE <u>George Hageage, M.D.</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7-23-68</u>	
22d. PHYSICIAN'S NAME (Type) George Hageage, M.D.						22e. ADDRESS 3717 38th Ave., Cottage City, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 25, 1968		Mt Herbron cemetery		Winchester Fredrick		Va	
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR DATE	
F. Gasch's Sons						Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED		2b. HOUR	
Candy			Ann			Austin		7-17-68 11:45am	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD
Female	White	Feb. 26 1968		4					7-17-68 11:45am
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington D.C.		U. S.				Prince George's Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince George Mt. Rainier					13e. STREET AND NUMBER 3802 33rd. Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			
BRUCE WAYNE AUSTIN			CAROLYN S. ASHLAND			*****			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO						BRUCE W. AUSTIN FATHER SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 795X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SDII DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 795.5									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)			John Kehoe MD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-18-68	
			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
BURIAL			7/19/68			EVERGREEN			ROANOKE VIRGINIA
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. GASCH'S SONS			HYATTSVILLE, MARYLAND			JUL 22 1968		Charles Judge	

585

WESTERN DIST.

1-17-1919  
[Faint, mostly illegible text follows, appearing to be a ledger or record with multiple lines of entries.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPT. OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
Frederick			H. Ball			July 10, 1968		10 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		Feb. 5, 1881		87 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Washington D.C.		U.S.A.				Prince George's Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital			Retired		Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George's		Seat Pleasant		YES <input type="checkbox"/> NO <input type="checkbox"/>		6195 Central Ave.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
HENRY S BALL			MARY P STREET							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give year or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			NO		7I9/03/I760 Lawrence C Ball POBox 26I Edgewater Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus -</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x Chronic anemia (Kimmel's disease)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
				4/2, 1968, to July 10, 1968, that (I) (we) last saw the deceased alive on July 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
David Anders, M. D.					3308 Dodge Park Rd., Landover, Md. 20785					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		7/13/68		Mt Olivet Cemetery		Washington D.C.				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Lee Funeral Home 300 4th St NE D.C.				JUL 15 1968		Charles Judge				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The pages remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) First Middle Last <b>Harry Arthur Barbour</b>			2a. DATE OF DEATH July Month 17 Day 1968		2b. HOUR 11:45 AM
3 SEX <b>male</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH <b>7-9-1892</b>		6 AGE (in years lost birthday) <b>76</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. PLACE (State or foreign country) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince Georges County</b> Md		
10. CITY OR TOWN OF DEATH <b>Oxon Hill</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4925 Deal Drive</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>bodyist</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Oxon Hill</b>	13d. INS. DE. CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>4925 Deal Drive</b>
14 FATHER'S NAME First Middle Last <b>Harry A. Barbour</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Sarah Tomlinson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>225 46 4794</b>	17 INFORMANT Address <b>McLean, Va. Paul H. Byers, Son-in-law, 6845 Summitt Rd</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>104L.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>170X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <b>58 July 17 68</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 16</b> , 19 <b>68</b> , to <b>July 17</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>July 16</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Herbert Wisotsky, M.D.</b>		22c. DATE SIGNED <b>7-17-1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Herbert Wisotsky, M.D.</b>	
23a. BURIAL, CREMATION, or other disposition <b>Burial</b>		23b. DATE <b>7-20-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Barnabas Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Oxon Hill, Maryland</b>		24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>			
25a. REC'D BY REGISTRAR <b>JUL 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <b>EDITH LORD BARCLAY</b>			2a DATE OF DEATH Month Day Year <b>7 12 68</b>			2b HOUR <b>8A M</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 2, 1877</b>		6 AGE (In years last birthday) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.		
7a BIRTHPLACE (State or foreign country) <b>N. H.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE Md.</b>				
10. CITY OR TOWN OF DEATH <b>BOWIE</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>12107 LERNER PL</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			12b KIND OF BUSINESS OR INDUSTRY <b>ILLUSTRATOR</b>	
3a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>P. G</b>		13c. CITY OR TOWN <b>BOWIE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>12107 LERNER PL</b>	
14 FATHER'S NAME First Middle Last <b>GEORGE W. LORD</b>			15 MOTHER'S M A D E N NAME First Middle Last <b>MARY JOHNSON</b>							
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>			16b SOCIAL SECURITY NO <b>001-36-1179</b>		17 INFORMANT <b>RALPH E. BARCLAY</b>		Address <b>SAME #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR OCCLUSION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death <b>4 HOURS</b> <b>5 YEARS</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>SSDX</b>										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (At home farm street factory office building, etc.)			21f LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 19 <b>66</b> , to <b>JULY</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>MAY 5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b SIGNATURE <b>Norman K. Bohrer</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>July 12, 1968</b>		
22d PHYSICIAN'S NAME (Type) <b>Norman K. Bohrer, M. D.</b>						22e ADDRESS <b>3231 Superior Lane Bowie, Md.</b>				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			23b DATE <b>7/12/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>			23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P. G. Md.</b>		
24 FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>						25a REC'D BY REGISTRAR <b>UL 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Continued - John Keller MD - Peppertown, P.M.C.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 103. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Debra	Middle Ann	Last Barrett	2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 7 Day 10 Year 1968			2b HOUR 9:00 P M
3 SEX F	4 RACE W	5 DATE OF BIRTH 20 July 1953	6 AGE (in years last birthday) 14 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 7 Day 10 Year 68			2d HOUR 10:00 P M
7a BIRTHPLACE (State or foreign country) MASS		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George Md			
10 CITY OR TOWN OF DEATH Clinton			NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Andrews Air Base			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) STUDENT		12b KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Georgia			13b COUNTY Ft. Benning		13c CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 210 Austin Loop.		
14 FATHER'S NAME First Middle Last FRANCIS XAVIER BARRETT			15 MOTHER'S MAIDEN NAME First Middle Last BARBARA ALICE BARRETT						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO N/A		17. INFORMANT ADDRESS Military Records-AAFB Hospital				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myelogenous leukemia and over 4 days</u> 2040 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subarachnoid</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 04:									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? WRGH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> By WRGH									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John K. Kroe, M.D., Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 7-11-68	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 16 JULY 1968		23c NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d LOCATION (City or town) (County) (State) ARLINGTON VA.			
24 FUNERAL DIRECTOR RINALDI FUNERAL HOME 7400 GEORGIA AVE. N.W.		ADDRESS DC 20012		25a REC'D BY REGISTRAR DATE JUL 15 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge			





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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
FIRST CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>LORETTA (LOURETTA) BEALL</b>					2a. DATE OF DEATH Month <b>7</b> Day <b>1</b> Year <b>68</b>			2b. HOUR <b>11:30 P.M.</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>AUG. 14 - 1879</b>			6 AGE (In years last birthday) <b>88</b> YRS		IF UNDER 1 YEAR MONTHS <b>88</b> DAYS <b>88</b>		IF UNDER 24 HRS. HOURS <b>88</b> MIN <b>88</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE</b> Md.						
10. CITY OR TOWN OF DEATH <b>FORESTVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>REGENT NURSING</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED - LANSHURGH</b>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <b>WASHINGTON</b>				13b. COUNTY <b>WASH. DC</b>		13c. CITY OR TOWN <b>WASH. DC</b>		13d. INSIDE CITY LIM IT? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>4237-ALABAMA AVE SE</b>		
14. FATHER'S NAME First <b>SAMUEL</b> Middle <b>J.</b> Last <b>OWENS</b>				15. MOTHER'S MAIDEN NAME First <b>MARY A.</b> Middle <b>McDONALD</b> Last <b>OWENS</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>				16b. SOCIAL SECURITY NO <b>578-01-3360</b>		17. INFORMANT <b>MAHEL E. BALDUIN</b> Address <b>5525-DAVIS BLVD SE</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CHRONIC URINARY TRACT INFECTION</b>												
2509 DUE TO, OR AS A CONSEQUENCE OF (b) <b>DIABETES MELLITUS</b>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>61X</b> (c) <b>8 YRS.</b>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>GENERALIZED ARTERIO SCLEROSIS</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If e ther, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (H) (this hospital) attended the deceased from <b>11-28</b> , 19 <b>67</b> , to <b>7-1</b> , 19 <b>68</b> , that (H) (we) last saw the deceased alive on <b>7-1</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>W.B. Steer M.D.</b>				DEGREE <b>MD.</b>		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7-1-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>WALTER B. STEER</b>				22e. ADDRESS <b>6400 MARLBORO PIKE SE. WASH. DC</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>July 5-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Mausoleum</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>						
24. FUNERAL DIRECTOR <b>Arnold Immura</b>				ADDRESS <b>Wash. DC</b>		25a. REC'D BY REGISTRAR <b>JUL - 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
JESSIE			Lorraine			Bennett			7 Month 16 Day 68 Year 9A. M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
F		W.		2-14-98			70 YRS						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
MICHIGAN			U.S.A.						PRINCE GEORGES Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
HYATTSVILLE			HYATTSVILLE NURS. HOME			GOVT. SECT.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
VA.			ARLINGTON			ARLINGTON						860 So. GREENBRIER	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
DANA			K. BENNETT			JESSA			E. BENNETT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address				
NO			578-32-0566			REV. BARCLAY BROWN			1370 LOCUST R.D. N.W.			WASHINGTON, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Cerebral Thrombosis										24 hrs			
DUE TO OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis										8 mo.			
DUE TO OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Arteriosclerotic Heart Disease & Atrial Fibrillation													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21c. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7-13, 1945, to 7-16, 1968, that (I) (we) lost saw the deceased alive on 7-16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE													
Louis Ross MD													
22c. DATE SIGNED 7-16-68													
22d. PHYSICIAN'S NAME (Type) Louis Ross													
22e. ADDRESS 1712 Eye St. N.W. Wash. DC 20006													
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			July 20, 1968			Oak Hill Cemetery			Grand Rapids, Michigan				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
J.W. Lee J.W. Lee			8434 Georgia Avenue			JUL 19 1968			J. Charles Judge				
Warner E. Pumphrey, Inc. Silver Spring, Md.													



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
TRONE THOMPSON BISHOP SR						Month Day Year			12:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 24 HRS	8. IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR
M	W	June 26 1915	33 YRS.	MONTHS DAYS	HOURS MIN	Month Day Year			1:05 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
VA		USA				Prince Georges Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince Georges Gen Bellman			Hotel			
13a. USUAL RESIDENCE (Where deceased lived, if not institution, residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
MD			Prin Puerdals			5708 - 64 Pl			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Alexander Hamilton Bishop			Pauline Owens						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS
Yes			WW 2			Mrs Irene Bishop Puerdals			5708 - 64 Pl
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Occlusion Rt & Left Coronary arteries									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) Arteries - Coronary Sclerosis									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
4201									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
DAITON O WATKINS						7-368			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			5318 Annapolis Rd			
			ADDRESS (Street, city, town or county)			Beadensburg Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 6, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.		JUL - 8 1968		J Charles Judge	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 404 MARYLAND STATE DEPARTMENT OF HEALTH  
9-24-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-13-68 198:30pm			2b HOUR		
Florence			I			Blankenship					
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	F UNDER 2 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year			2d HOUR
Female	White	2-23-1915	53 YRS					7 13 68			11:06pm
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Canada			U.S.A.						Prince George's		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Unemployed					
13a U.S.A. RESIDENCE (Where deceased lived, if institution give street address)			13b CITY OR TOWN			13c INSIDE CITY, MILE? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
District of Columbia			Washington						1508 V Street, S.E.		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MÄDEN NAME First Middle Last								
Cecil Mattice			Cecilia ?								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
No			224-34-9380			Andrew E. Blankenship-son			Ontario, Ca.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intoxication</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Ethyl alcohol</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			John Kehoe MD Riverdale Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			7-13-68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			7-19-1968			Cedar Hill Cemetery			Suitland, Maryland		
24 FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Lee Funeral Home-300 4th St. NE Wash., D.C.						JUL 22 1968			25b. REGISTRAR'S SIGNATURE		
									Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
10403  
10414  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Harry Middle T Last Bolton			2a. DATE OF DEATH Month July Day 16 Year 1968			2b. HOUR 2.30 AM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH 13 May 1897		6 AGE (In years last birthday) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Bethesda Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Pr. Geo.			
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) fireman		12b. KIND OF BUSINESS OR IND. STR. <i>of agriculture</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 308 Second Street	
14 FATHER'S NAME First Edward Middle Bolton Last			15 MOTHER'S MAIDEN NAME First Ida Middle Oden Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		16b. SOCIAL SECURITY NO (If yes give war or dates of service) WWI 215-38-477		17 INFORMANT Leola Bolton		Address 308 2nd St Laurel Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <del>200</del> Cardiac arrest 41 i DUE TO, OR AS A CONSEQUENCE OF (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from July 14, 1968 to July 16, 1968, that (I) (we) last saw the deceased alive on July 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Don B. Cameron				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED July 16, 1968	
22d. PHYSICIAN'S NAME (Type) Don B. Cameron, M. D.				22e. ADDRESS 3503 Perry St., Mt. Rainier, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-18-68		23c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery		23d. LOCATION (City or Town) (County) (State) Scaggsville Md.			
24. FUNERAL DIRECTOR Name Address N. Adams D.H. Laurel, Md.				25a. RECEIVED BY REG. STRAR DATE JUL 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

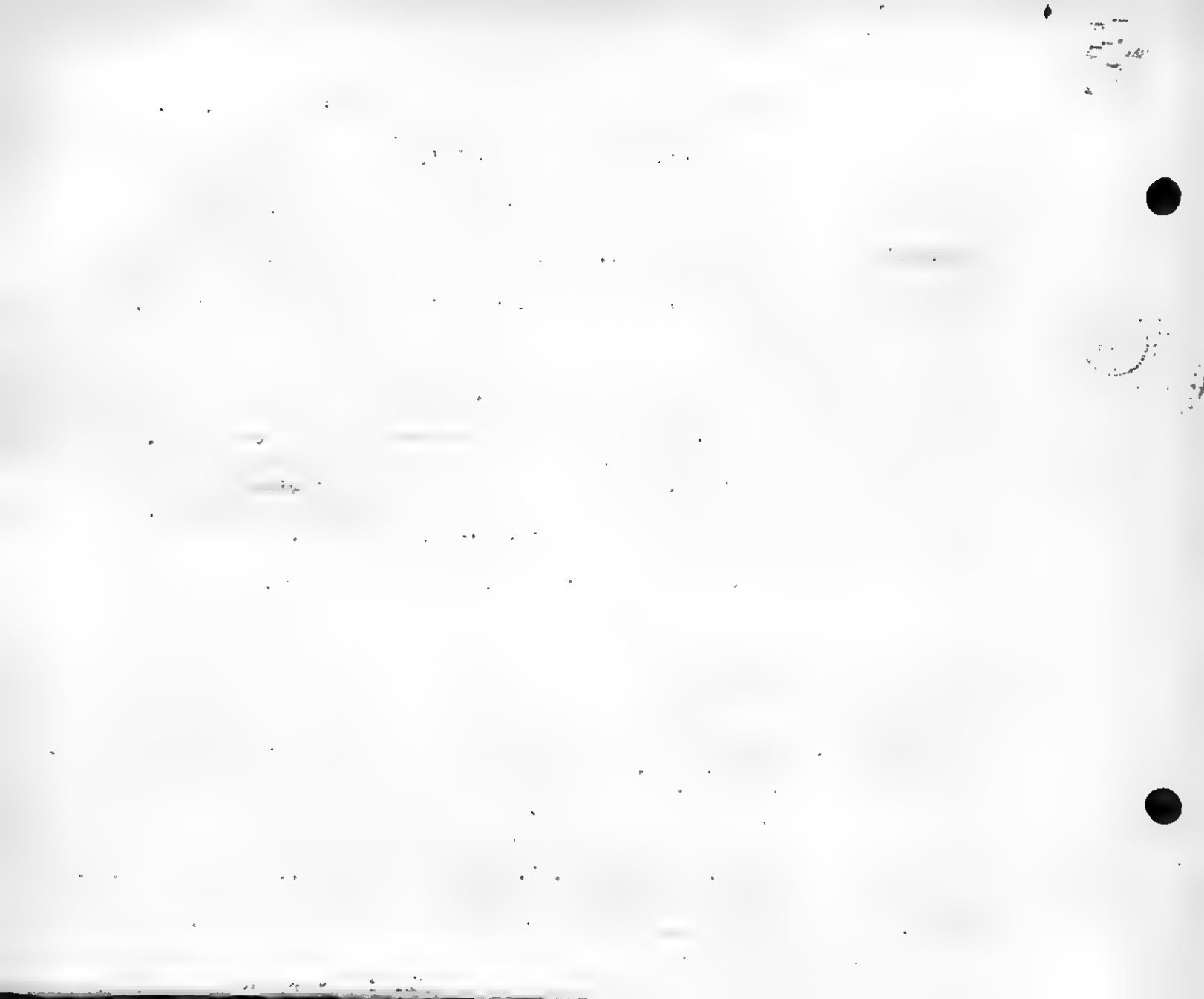


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <b>Marie M. Bosc</b>			2a. DATE OF DEATH Month Day Year <b>July 14, 1968</b>		2b. HOUR <b>1:55 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>3/24/1892</b>		6. AGE (In years last birthday) <b>76</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b> Md		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		
13a. U.S.A. RESIDENCE (Where deceased admission) STATE <b>Maryland</b>	13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Seat Pleasant</b>	13d. INSIDE CITY, TOWN, OR VILLAGE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>6470 Addison Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Unknown</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac failure with pulmonary edema &amp; congestion.</b> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic passive congestion of liver with centrilobular</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis, severe.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Status 2 week post resection of abdominal aortic aneurysm.</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)	21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>March, 1968</b> , to <b>July 14, 1968</b> , that (I) <del>(was)</del> lost saw the deceased alive on <b>July 14, 1968</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(did)</del> <b>(did not)</b> view the body after death.					
22b. SIGNATURE <b>Wm A. Holbrook</b>	22c. DATE SIGNED <b>July 15, 1968</b>	22d. PHYSICIAN'S NAME (Type) <b>William A. Holbrook, M. D.</b>			
22e. ADDRESS <b>4500 College Ave., College Park, Md. 20740</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/17/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Maryland</b>		
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons, Co.</b>	ADDRESS <b>300 4th St, Wash. DC</b>	25a. REC'D BY REGISTRAR <b>JUL 17 1968</b>	25b. REGISTRAR'S SIGNATURE <b>John Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
Item #6, Film 4102 7/11/68 km									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
WALLACE E. BOWEN						Month Day Year JULY 5 1968		2:30	
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male	White	SEPT. 27, 1903		65 5 YRS.					
7a BIRTH-PLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
South Carolina		U.S.				Prince Georges Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Georges Hospital		Carpenter		Building			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b CITY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Prince George		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4707 Sheridan Street	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
			Hester Costello						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address				
No			579-05-7216		Abbie A. Bowen Wife Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Massive Hemorrhage</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ruptured pulmonary artery</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>bronchogenic carcinoma</i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <i>Nov 1967</i> to <i>July 5 1968</i> that (I) (we) last saw the deceased alive on <i>July 5 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Don B. Cameron</i> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>July 2, 1968</i>			
22d PHYSICIAN'S NAME (Type) Don B. Cameron M.D.				22e ADDRESS Perry St. Mt. Rainier, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		7/8/68		Pin Oak Grove Cemetery		Zepp		Virginia	
24 FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Maryland		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE <i>J Charles Judge</i>	
						JUL - 8 1968			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Item 18 Film 404 8-28 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Mildred			A Bowles			EST MATED <input checked="" type="checkbox"/> July 3 1968			12:00 P.M.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
F	W	April 11-1910	58 YRS	MONTHS	DAYS	HOURS	MIN	July 10	1968	12:00	P.M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md		
West Virginia		U.S.					PRINCE GEORGE				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
CHEVERLY			PRINCE GEORGE GENERAL			HOUSEWIFE			HOME		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			PRINCE GEORGE			BLADENSBURG				4307-57th Ave.	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
CLIFTON E. SULABAUGH			CARRIE RUPPEATHAL								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
NO			378-01-5588			Frances Michael sister Williamsport, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Lawrence Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema, Severe</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(Etiology undetermined)</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Dayton Watkins</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-5-68			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b DATE SIGNED			DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 5318		
EXAMINER'S NAME (Type) DAYTON WATKINS			ADDRESS (Street, city, town, or county) Bladensburg								
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		7/8/68		Ft. Lincoln Cemetery		Colmar Manor Maryland					
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons Hyattsville, Maryland				JUL - 8 1968		Charles Judge					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 20M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7 13 19 68 4:45 PM		2b HOUR
William J		Brauer					
3. SEX M	4 RACE W	5 DATE OF BIRTH 29 July 1914		6 AGE 53 YRS	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD Month 7 Day 13 Year 68 5:17 PM
7a BIRTHPLACE (State or foreign country) Balto. City		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George Md.	
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) C.O.P. Telephone Co.		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md		13b COUNTY Reisterstown		13c CITY OR TOWN Reisterstown		13d NO. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME John Brauer		15 MOTHER'S M.A.DEN NAME Theresa Plock		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b SOCIAL SECURITY NO 212-05-0922	
16c CITY OR TOWN		17 INFORMANT Mrs. Eugenia Brauer Reisterstown, Md.		17 ADDRESS		17b STREET AND NUMBER 118 2nd Ave.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4127 Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 720							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED 7-14-68			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE July 17, 68		23c NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d LOCATION (City or Town) (County) (State) Finksburg, Md.	
24 FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.		ADDRESS		25a. RECD BY REGISTRAR DATE JUL 16 1968		25b REGISTRAR'S SIGNATURE J. Charles Judge	



# FOR STATE HEALTH DEPT.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> 7-14-68 192:10am			2b. HOUR				
Annie E Brown													
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 7 Day 14 Year 68 19 2:10am			2d. HOUR		
Female	Negro	4 March 1889	79 YRS										
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md				
Maryland		USA				Prince George's							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)				12a. OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly				Prince George Hospital									
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission, STATE)				13b. COUNTY				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland				Prince George Seat Pleasant								6407 Kolb Street	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
unknown				Mary Edglen									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A M P M 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)				John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county)				22b. DATE SIGNED 7-15-68	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				7/19/68		Woodlawn Cemetery				Washington, D.C.			
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd., N.W.						25a. REC'D BY REG STRAR JUL 16 1968		25b. REG STRAR'S SIGNATURE J Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove top-on papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
VICTORIA							BROWN		Month 7 Day 16 Year 68			9-29 M
3 SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
F		WHITE		4/10/79			89 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Wash. DC			USA					PRINCE GEORGES Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
FORESTVILLE			REGENT NURSING HOME						Nurse		Name	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER			
Md			P.G.		Laurel				927 7th Street			
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME First Middle Last			
Joseph Arth Brown									Henrietta Scala			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address			
no						Richard R. Anderson			927 7th St Laurel Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CORONARY THROMBOSIS											8 HRS.	
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE											YRS	
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
Cerebral Thrombosis - Old												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (H) (this hospital) attended the deceased from 3-20, 1968, to 7-16, 1968, that (H) (we) last saw the deceased alive on 7-16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.												
22b SIGNATURE			22c DATE SIGNED			22d PHYSICIAN'S NAME (Type)			22e ADDRESS			
W.B. Sheer M.D.			7-16-68			WALTER B. SHEER			6400 MARLBORO PKE S.E. WASH. D.C.			
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			7-19-68		Washington Natl			Suitland Md.				
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE				
Kendall Funeral Home Laurel Md						JUL 22 1968		Charles Judge				

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

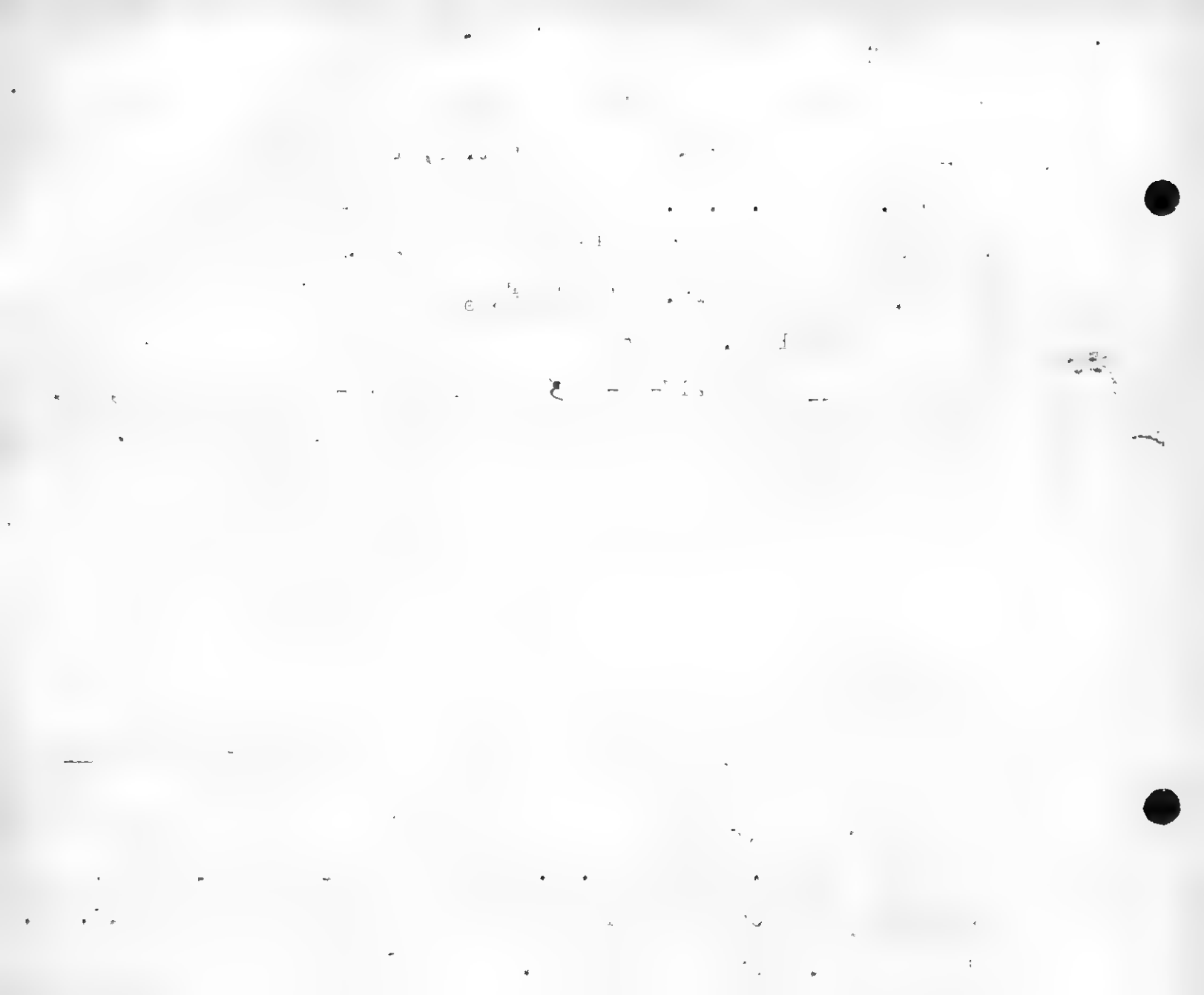
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year		2b HOUR		
William O. Brown						July 14, 1968		2:30 M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Caucasian		Aug. 29, 1905		62 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				
Laurel Md		C.S.A.				Prince George's Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geor.Gen'l Hospital			Teacher		Army Yard		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince George's		Laurel		YES		Cherrylane Road	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Walter O. Brown			Sarah Seishear							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown			16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
No					Velma Grimes, Laurel Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 2										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		State		
22a. I certify that (this hospital) attended the deceased from <u>July 13, 1968</u> , to <u>July 14, 1968</u> , that <del>it</del> (we) last saw the deceased alive on <u>July 14, 1968</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Donald C. Edgren</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c DATE SIGNED July 15, 1968			
22d. PHYSICIAN'S NAME (Type) <u>Donald Edgren, M. D.</u>					22e. ADDRESS <u>Prince Geo. Plaza, Hyattsville, Md, 20783</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
<u>Burial</u>		<u>7-17-68</u>		<u>St. Peter's Cem.</u>		<u>Laurel Md</u>				
24 FUNERAL DIRECTOR <u>De Witt Lianedean, Laurel Md</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE			
					DATE <u>JUL 22 1968</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A. M. P. M.
Bruce Louis Buck						July 13, 1968			12 M
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7. IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
Male		White		Oct. 1, 1875		92 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		U. S. A.				Prince Georges Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Upper Marlboro			Old Crain Highway			Tobacco Farming		Own Farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.			Pr. Geo's			Upper Marlboro		Old Crain Highway	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Daniel R. Buck						Susan -- Robison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
No			217-36-658			Russell Buck - Upper Marlboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> 437.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>46</u> , to <u>July 13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8 May</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert B. Sasscer</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/13/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Robert B. Sasscer, M. D.</u>						22e. ADDRESS <u>Upper Marlboro, Md. 20870:</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		7/16/68		Trinity Cemetery		Upper Marlboro		P.G. Md.	
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ritchie Bros. Upper Marlboro, Md.						DATE <u>JUL 24 1968</u>		<u>Charles J. J...</u>	



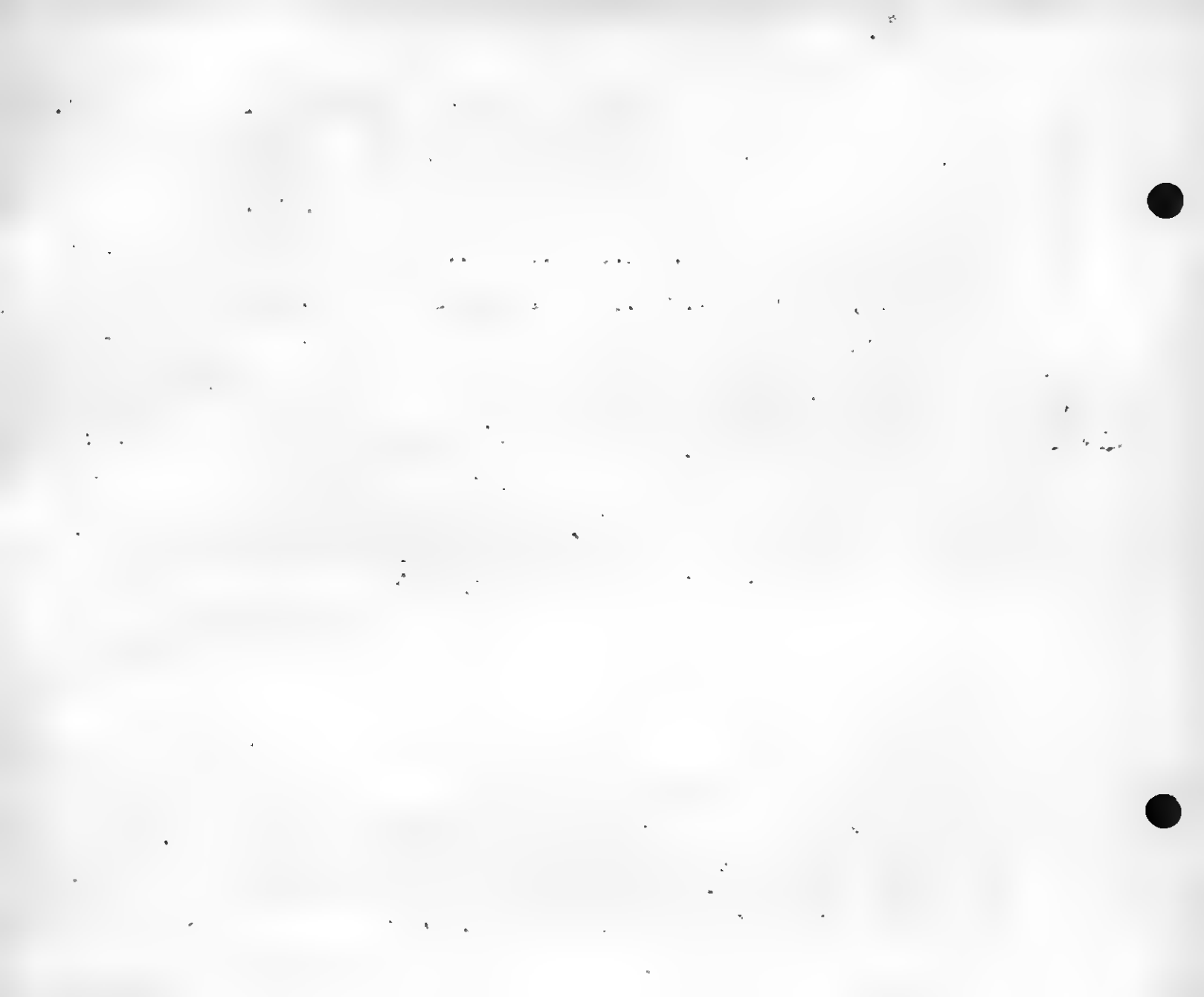
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115 (1)  
30M REV. 7/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) <b>Dorrance B Burdick</b>						2a. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR <b>11:55 PM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>10 June 1917</b>			6 AGE (in years last birthday) <b>49 51 RS.</b>		7 UNDER 1 YEAR MONTHS <b>49</b> DAYS <b>51</b>		8 IF UNDER 24 HRS. HOURS <b>11</b> MIN. <b>55</b>	
7a. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Pr. Geo.</b>			Md			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo., Gen., Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>S.A.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Pr. Geo.</b>			13c. CITY OR TOWN <b>College Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4816 Erie Street</b>		
14. FATHER'S NAME First <b>Bernie</b> Middle <b>Purdick</b> Last <b>Burdick</b>				15. MOTHER'S M.A.D.E.N. NAME First <b>Jeanette</b> Middle <b>Brown</b> Last <b>Burdick</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, age, or unknown) <b>88</b> (If yes give year or dates of service)				16b. SOCIAL SECURITY NO. <b>578166190</b>		17. INFORMANT <b>Thomas Dunn</b>			Address <b>College Park, Md.</b>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary edema</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hrs.</b> <b>24 hrs.</b> <b>15 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic acute cholecystitis</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <b>June 19 55</b> to <b>7/27, 1968</b> , that (I) (we) last saw the deceased alive on <b>7/27</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death												
22b. SIGNATURE <b>Norman D. Comeau</b>						22c. DATE SIGNED <b>7/28/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Norman D. Comeau</b>		22e. ADDRESS <b>Mt Rainier Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7/31/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>						
24. FUNERAL DIRECTOR <b>Valley Funeral Home Mt. Rainier, Md.</b>						25a. REC'D BY REGISTRAR <b>JUL 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

MEDICAL CERTIFICATION





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

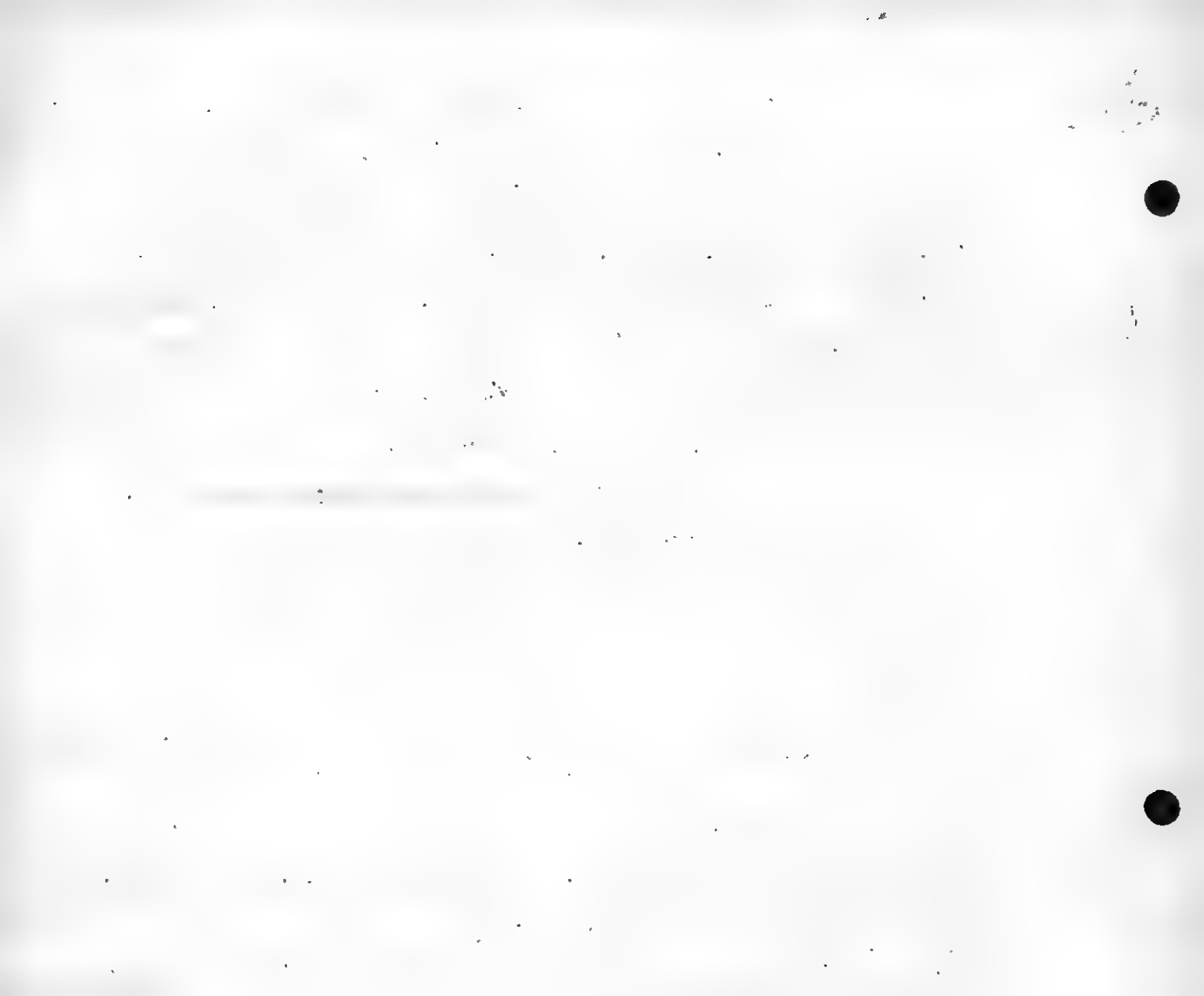
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED		2b HOUR		
Edward Leo Burns						7-20-68		10:16pm		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR	7 UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR		
Male	White		50? YRS	MONTHS DAYS	HOURS MIN	Month Day Year		10:32pm		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
						Prince George's Md				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital							
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before death on, STATE)			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Florida					St. Petersburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		1743 3rd. Avenue	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO, OR AS A CONSEQUENCE OF <u>Trauma - struck by car</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year 10:15pm 7-20-19 68			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
						Pedestrian struck by car.				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No. City or Town County State				
			Rt. 5 and Rt. 301.			Prince George County, Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
			John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-21-68		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
REMOVAL			8-1-68		Amd. Del. of Ind. Univ of Md.		Baltimore, Md.			
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
CHAMBERS						DATE AUG 5 1968				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

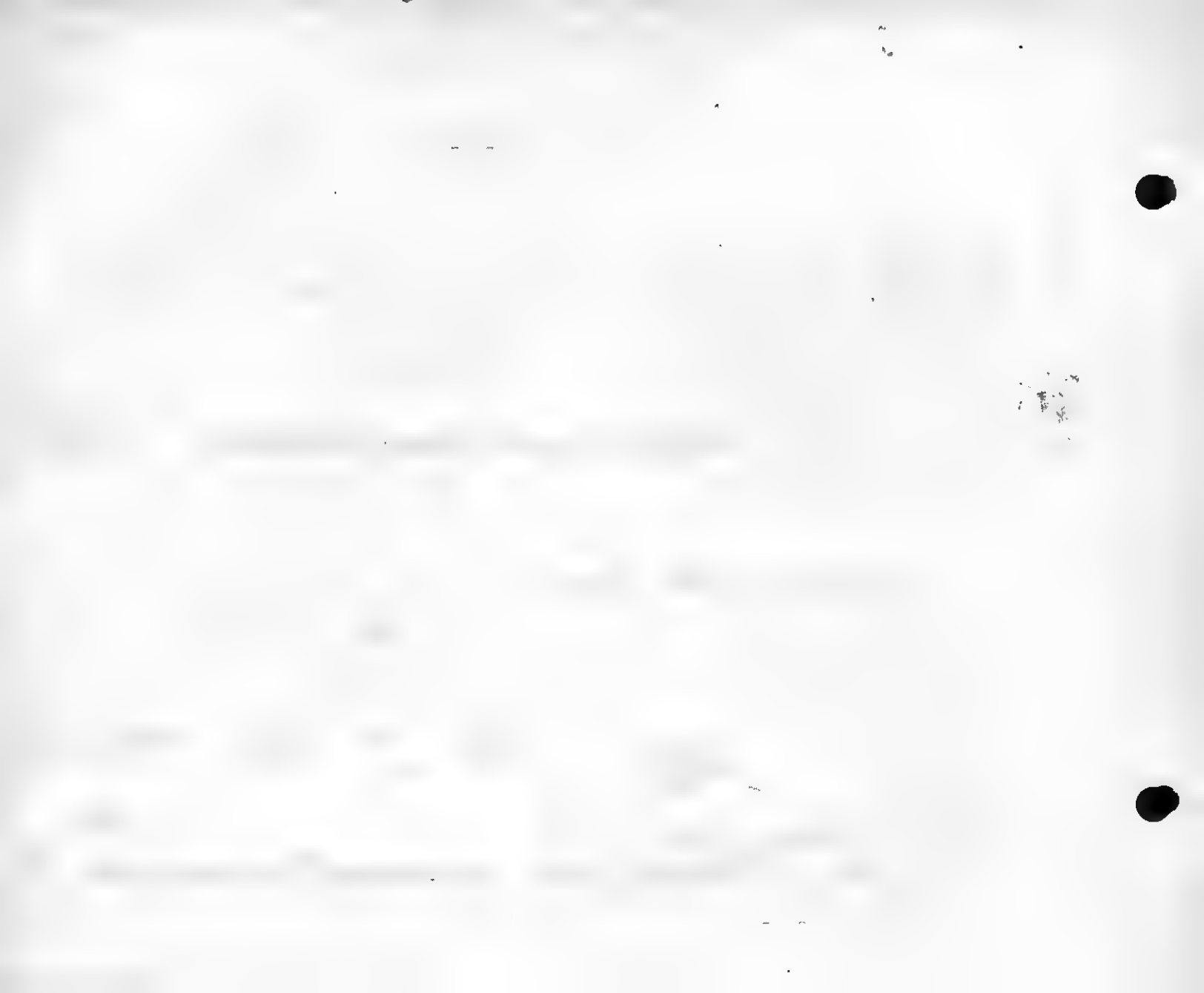
MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
James Butler						July 15, 1968		10:55 P		
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Negro		6/12/1902		65 56 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland		U.S.A.				Prince George's		Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital			Retired - Gov't.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. NSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George's		Fairmont Hgts.		YES <input type="checkbox"/> NO <input type="checkbox"/>		721 59th Avenue	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
Summie M. Butler			Georgianna M. Butler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
No			None		Thomas Butler Same as 13E					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia.</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) <u>Cancer of the Urethra with widespread metastasis.</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Emaciation.</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from July 15, 1968, to July 15, 1968, that (I) (we) last saw the deceased alive on July 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
Ohannes Sahakyan, M. D.								July 16, 1968		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS							
			6001 Landover Rd., Cheverly, Md. 20785							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
		7-19-68		Mt Olivet		Washington D.C.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
145 Washington & Sm 4925			Derne			JUL 22 1968		J Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARTYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) Rita			First Middle Last M. Butterworth			2a. DATE OF DEATH Month Day Year 7 15 68		2b. HOUR 9:05 PM	
3 SEX F		4. RACE W		5. DATE OF BIRTH 5-19-05		6. AGE (In years last birthday) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Australia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md			
10. CITY OR TOWN OF DEATH Forestville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN Hillcrest Heights		13d. INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2708 Gaither Street	
14. FATHER'S NAME First Middle Last ? Maasydk			15. MOTHER'S MAIDEN NAME First Middle Last Nancy Dowling						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Husband) Horace Butterworth,		Address Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma right breast - metastatic 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Fracture left femur									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 11/15, 1950, to 7/15, 1968, that (I) (we) last saw the deceased alive on 7/14/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Leo H. McGowan M.D.				DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 7/15/68	
22d. PHYSICIAN'S NAME (Type) Leo H. McGowan, M.D.				22e. ADDRESS 2711 Gaither St., Hillcrest Heights, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-17-68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) Suitland, Maryland		(County) (State)	
24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland				25a. REC'D BY REGISTRAR JUL 19 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

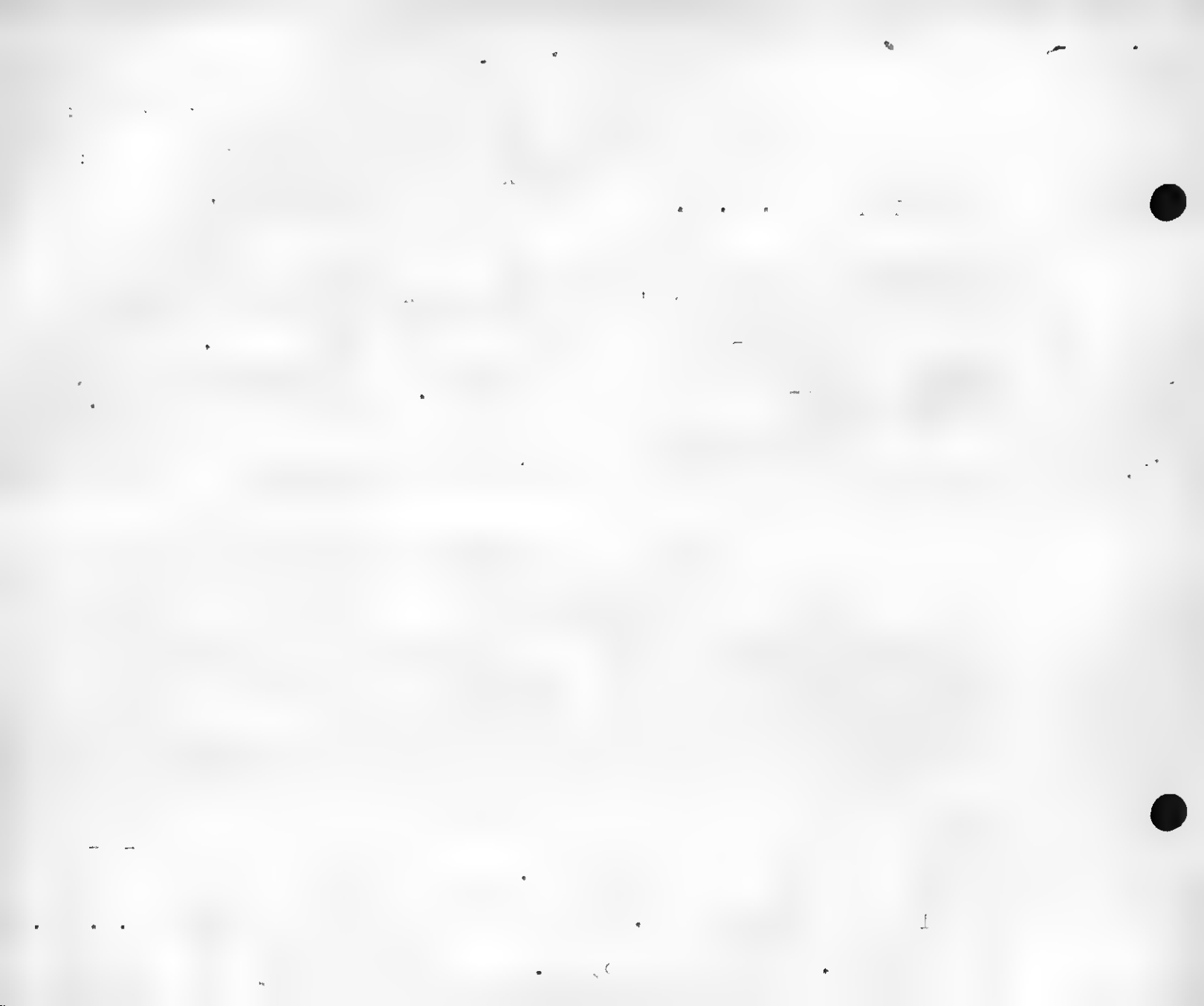


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-15-68		2b HOUR 192:00am	
James Robert Canter									
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	
Male	White	30 July 1918	49 YRS					7 15 68 199:30am M	
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		U. S. A.				Prince George's Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George Hospital		Tobacco Farming		Tenant			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Prince George's		Upper Marlboro				No Fixed Address	
14. FATHER'S NAME First Middle Last			5 MOTHER'S MAIDEN NAME First Middle Last						
Joseph -- Canter			Cora E. Smith						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
					2200 Ritchie Rd., Forestville, Md. 20028				
8 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1200</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 7-16-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/22/68		Mt. Carmel Cemetery		Upper Marlboro, P.G. Md.			
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Ritchie Bros. Upper Marlboro, Md.						DATE JUL 24 1968		J Charles Judge	

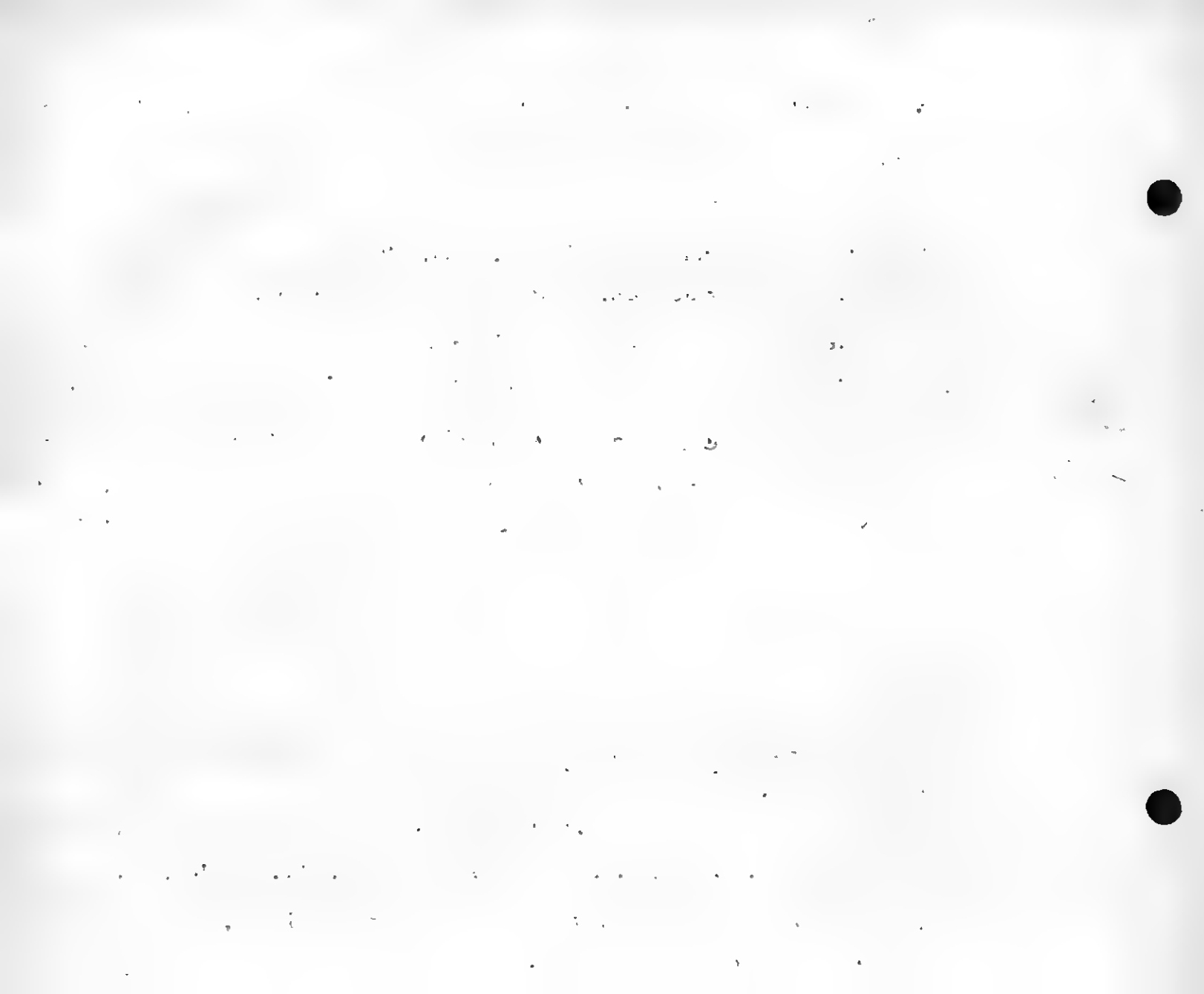




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First <b>Charles</b>		Middle <b>A.</b>		Last <b>Carl</b>		2a. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1968</b> 2b. HOUR <b>2:45A</b> M		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>11/9/92</b>			6 AGE (In years last birthday) <b>75</b> YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Gen. Hosp.</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Police</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Police Co.</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Geo.</b>		13c CITY OR TOWN <b>Brentwood</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>3506 Taylor Street</b>		
14. FATHER'S NAME First <b>August</b>			Middle <b>Carl</b>		Last <b>Matelda</b>		15. MOTHER'S MAIDEN NAME First <b>Hagedors</b>		Middle <b>Hagedors</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>None</b>			16b. SOCIAL SECURITY NO. <b>208095647</b>		17 INFORMANT Address <b>Goldie Carl (Wife) 3506 Taylor St.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>										<b>4 days</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>BIL PNEUMONIA</b>										<b>1 week</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>PARKINSON'S DISEASE</b>										<b>16 YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>July 26, 1968</b> to <b>July 27, 1968</b> , that (I) <del>(see)</del> saw the deceased alive on <b>July 26, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> (did not) view the body after death.											
22b. SIGNATURE <b>Benjamin S. Miller M.D.</b>						22c. DATE SIGNED <b>July 27, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Benjamin S. Miller, M.D.</b>			
22e. ADDRESS <b>3824 34th St., Mt. Rainier, Md.</b>						22f. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/30/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Prospect Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hickory, Pa.</b>		24. FUNERAL DIRECTOR <b>Valley Funeral Home Mt. Rainier, Md.</b>			
25a. REC'D BY REGISTRAR <b>JUL 30 1968</b>						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



## CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Otho V Carpenter						July 17 1968			12, 30 AM		
3. SEX		4 RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
Male		Negro		11 June 1888			80 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 COUNTY OF DEATH				
N. C.		U.S.A.					Pr. Geo., Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Pr. Geo. Gen., Hosp.			Moulder			Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			P.G.		Wash., D.C.				5325 Nye St.,		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Frank Carpenter			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
					Catherleen Mayhew-828 20th Street, N. E						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 7-1-68 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from June 29, 1968, to July 17, 1968, that (X) (we) lost saw the deceased alive on July 17, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Donald C. Edgren</u>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED July 17, 1968				
22d. PHYSICIAN'S NAME (Type) Donald Edgren, M. D.					22e. ADDRESS Prince George's General Hospital, Cheverly						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		7-21-68		Church Semetery			Wakelore, North Carolina				
24. FUNERAL DIRECTOR John T. Rhines Co. Washington, D. C.					25a. REC'D BY REGISTRAR DATE JUL 22 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print) First Middle Last <b>George Samuel Carrington</b>						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-18-68 193:22am M		2b. HOUR	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>12-23-1928</b>	6 AGE (In years last birthday) <b>39</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <b>7 18 68</b>		2d. HOUR <b>4:26am</b>	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Truck Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Preston Lines</b>		
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE <b>Virginia</b>		13b. COUNTY <b>Chesterfield</b>		13c. CITY OR TOWN <b>Richmond</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>4141 Norbeth Avenue</b>	
14 FATHER'S NAME First Middle Last <b>George S. Carrington</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Florence Thomas</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>Korean</b>				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS <b>Richmond Va.</b> <b>Irene Miller Carrington 4141 Narbeth Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>LACERATION OF BRAIN</b> DUE TO, OR AS A CONSEQUENCE OF <b>TRAUMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>NO TO ACCIDENT</b> (c) <b>NO TO ACCIDENT</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MIN</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>3:20am 7-18-19 68</b>		21c. HOW INJURY OCCURRED <b>Struck pillar of overpass. Driver of truck which went out of control and</b>					
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Rt. 50 and Ardmore Ardwick Road, Prince George County, Maryland</b>		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Kehoe MD</b>		EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <b>7-19-68</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wards Chapel</b>		23d. LOCATION (City or Town) (County) (State) <b>Nottoway County Virginia</b>			
24. FUNERAL DIRECTOR <b>Joseph W. Bliley Co</b>		300 E. Marshall St. Richmond, Va.		25a. REC'D BY REGISTRAR <b>JUL 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print) First Middle Last <b>Herbert Hoover Chandler</b>						2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-13-68 199:17pmM		2b HOUR	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>8-13-1932</b>	6 AGE (In years last birthday) <b>35</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year <b>7 13 1968</b>		2d HOUR <b>19:50pm M</b>	
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>			
10 CITY OR TOWN OF DEATH <b>Bladensburg</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to g va street address) <b>4275 58th. Avenue</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>MAINT. MAN</b>		12b KIND OF BUSINESS OR INDUSTRY <b>APARTMENTS</b>	
13a USUAL RESIDENCE (Where deceased lived, if not tuition. Residence before) <b>Maryland</b>		13b COUNTY <b>Prince George's</b>		13c CITY OR TOWN <b>Bladensburg</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>4275 58th. Avenue</b>	
14. FATHER'S NAME First Middle Last <b>Elisha Chandler</b>				15 MOTHER'S M A DEN NAME First Middle Last <b>Elvira Cutshaw</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16b SOCIAL SECURITY NO <b>UNKNOWN</b>		17 INFORMANT <b>Elvira Chandler</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Gun shot wound of head</b> <b>955X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>6X</b>									
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <b>9:17pm 7-13- 19 68</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Shot self in head</b>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>home</b>		21f LOCATION Street or RFD No City or Town County State <b>same as # 13</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL EXAMINER'S NAME (Type) <b>John Kehoe MD</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b DATE SIGNED <b>7-14-68</b>	
EXAMINER'S NAME (Type) <b>John Kehoe MD</b>				ADDRESS (Street, city, town, or county) <b>Riverdale, Md.</b>					
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE <b>7-19-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>CULPEPPER NAT'L</b>		23d LOCATION (City or Town) (County) (State) <b>Culpepper VA</b>			
24 FUNERAL DIRECTOR <b>W. W. Chambers Co. Riverdale Md.</b>				25a REC'D BY REG STRAR DATE <b>JUL 18 1968</b>		25b REG STRAR'S SIGNATURE <b>J. Charles Judge</b>			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 42 hours after death.

## 10423 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

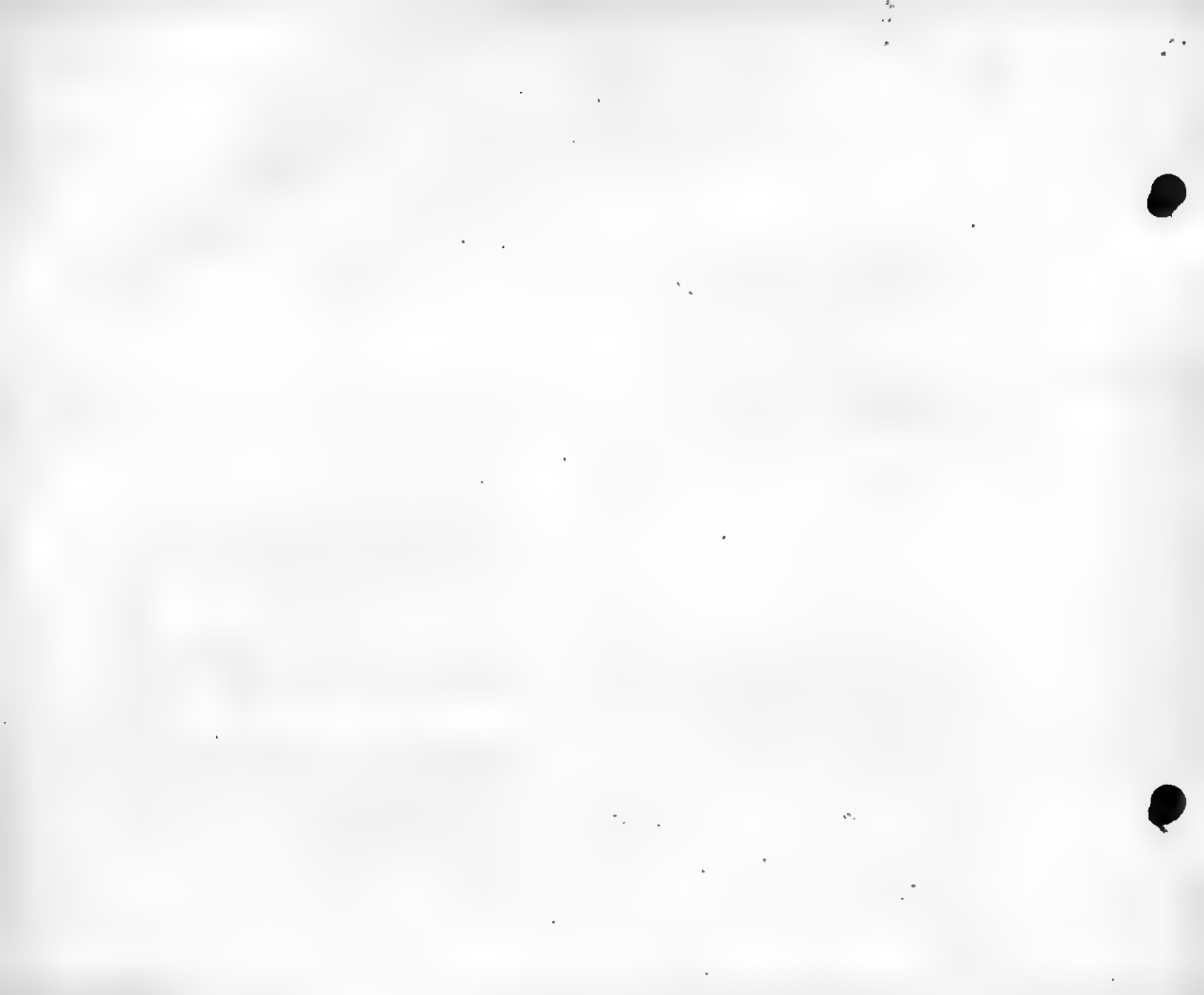
1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-13-68			2b HOUR 19:15pm
Joanne Louise Chandler									
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER YEAR MONTHS YEARS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD	2d HOUR
Female	White	1-11-1931	37 YRS					Month Day Year 7 13 68	9:50pm
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.				Prince George's			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		2b. KIND OF BUSINESS OR INDUSTRY	
Bladensburg			4275 58th. Avenue						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Prince George		Bladensburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		4275 58th. Avenue
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
ROGER ALLEN			LOUISE DONOVAN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT ADDRESS			
NO						WILLIAM H. POKA BAUGH RIVERDALE MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head									
965X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
481X									
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			9:15am 7-13-19 68			Shot during altercation.			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No		City or Town County State	
			home			same as #13			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			John Kehoe			M.D.		22b. DATE SIGNED	
EXAMINER'S NAME (Type)			John Kehoe MD			Riverdale, Md.		7-14-68	
23a BURIAL CREMATION			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			7-18-68		St. Lincoln		Columbia Manor Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. W. Chamber Co. Riverdale Md.						JUL 19 1968		Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

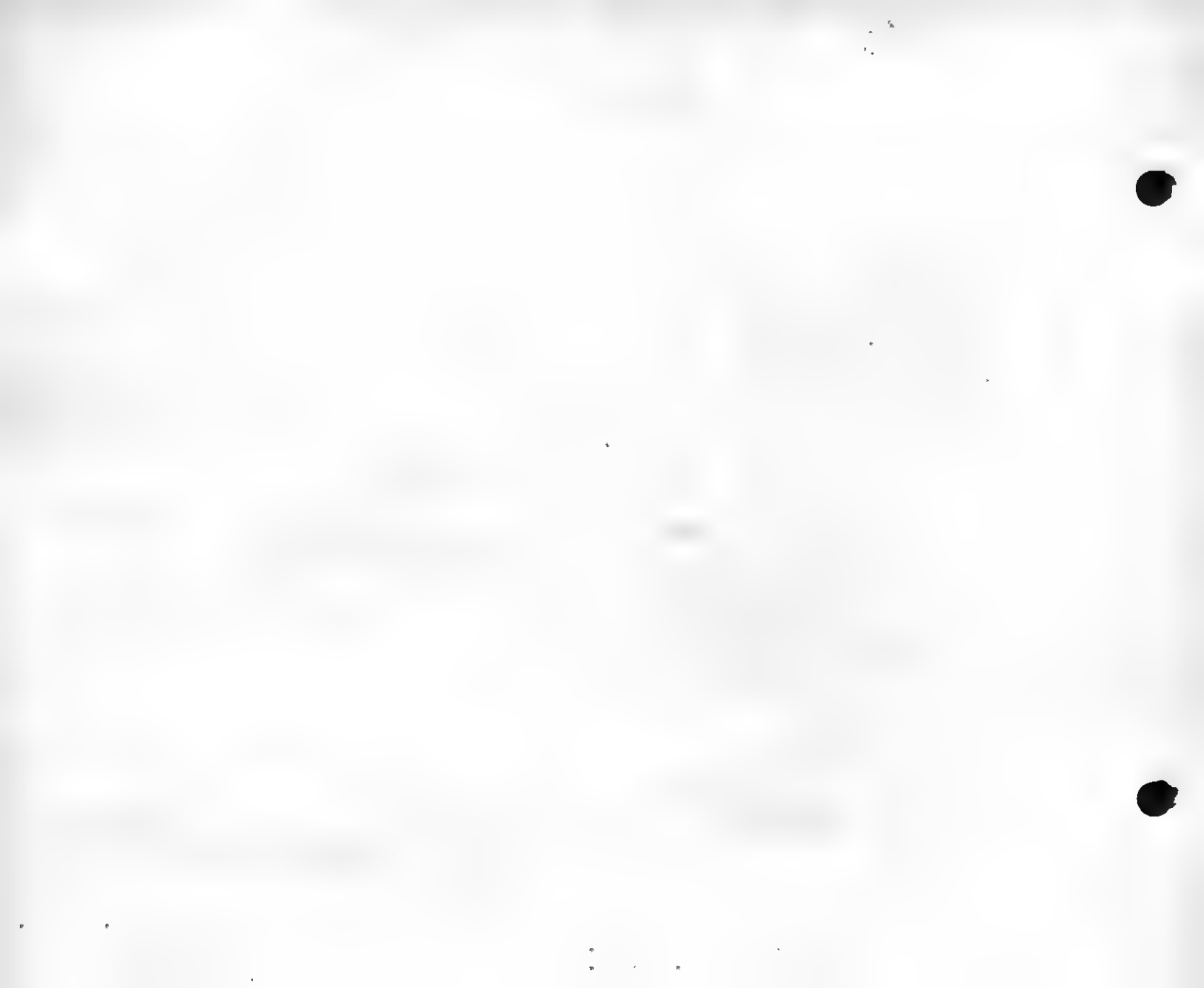
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print) <b>JAMES MENDENHALL CHISHOLM Sr</b>		First		Middle		Last		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>July 5 1968</b>		2b HOUR <b>M</b>		
3 SEX <b>M</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>Dec 7 1891</b>		6 AGE (in years last birthday) <b>76 YRS</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		F UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>		2c DATE PRONOUNCED DEAD Month <b>July</b> Day <b>5</b> Year <b>1968</b> <b>22 AM</b>		
7a BIRTHPLACE (State or foreign country) <b>Scarsdale</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Pt George</b>						
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Auto Salesmen Rte</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>auto</b>		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Md</b>		13b COUNTY <b>Pt Geo Edmonston</b>		13c CITY OR TOWN		3d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>5107 Decatur</b>				
14 FATHER'S NAME <b>James M NETTLES</b>				First		Middle		Last		15 MOTHER'S MÄDEN NAME <b>Christina Ford</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b>		(If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17. INFORMANT <b>Police records</b>			ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Arterio Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State		
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Dayton O Walker</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		7-5-6V		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5318annopolisK		ADDRESS (Street, city, town, or county) <b>Bladensburg Rd</b>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>7/8/1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Congressional</b>		23d LOCATION (City or Town) <b>Wash. D.C.</b>		(County)		(State)		
24 FUNERAL DIRECTOR <b>Takeda Mattingly</b>		ADDRESS <b>131-174</b>		25a RECD BY REGISTRAR <b>AUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year		2b. HOUR	
CATHERINE RUSSEL CHRISTOPHER						July 6 1968		3:10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		2/20/1899		69 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Iowa		U.S.A.				Prince Georges		Hyattsville	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Hyattsville Nursing Home		Retired schoolteacher							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY - IN 1ST? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
D.C.				Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1600 - 16th St., N.W.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
James G. Russel						Fannie Filson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
no		577-52-2850		Nursing Home Records		same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Pneumonia</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Indistinct obstruction</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of Pancreas</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>151X</u> <u>cachexia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
10/2/67		Obstructive jaundice		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No		City or Town	County State
22a. I certify that (I) (the hospital) attended the deceased from <u>7/6</u> , 19 <u>68</u> , to <u>7/6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death		22b. SIGNATURE <u>Edward S. Mehlman</u>		M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>7/6/68</u>	
22d. PHYSICIAN'S NAME (Type)		Edward S. Mehlman, M.D.		22e. ADDRESS		MEDICAL ARTS BUILDING 6480 NEW HAMPSHIRE AV. TAKOMA PK, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		7/10/68		Cedar Hill Cemetery		Prince Georges Co.			Md.
24. FUNERAL DIRECTOR		The S. H. Hines Co.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
2901 14th St. N. S.		Washington DC		JUL - 9 1968		Charles Judge			

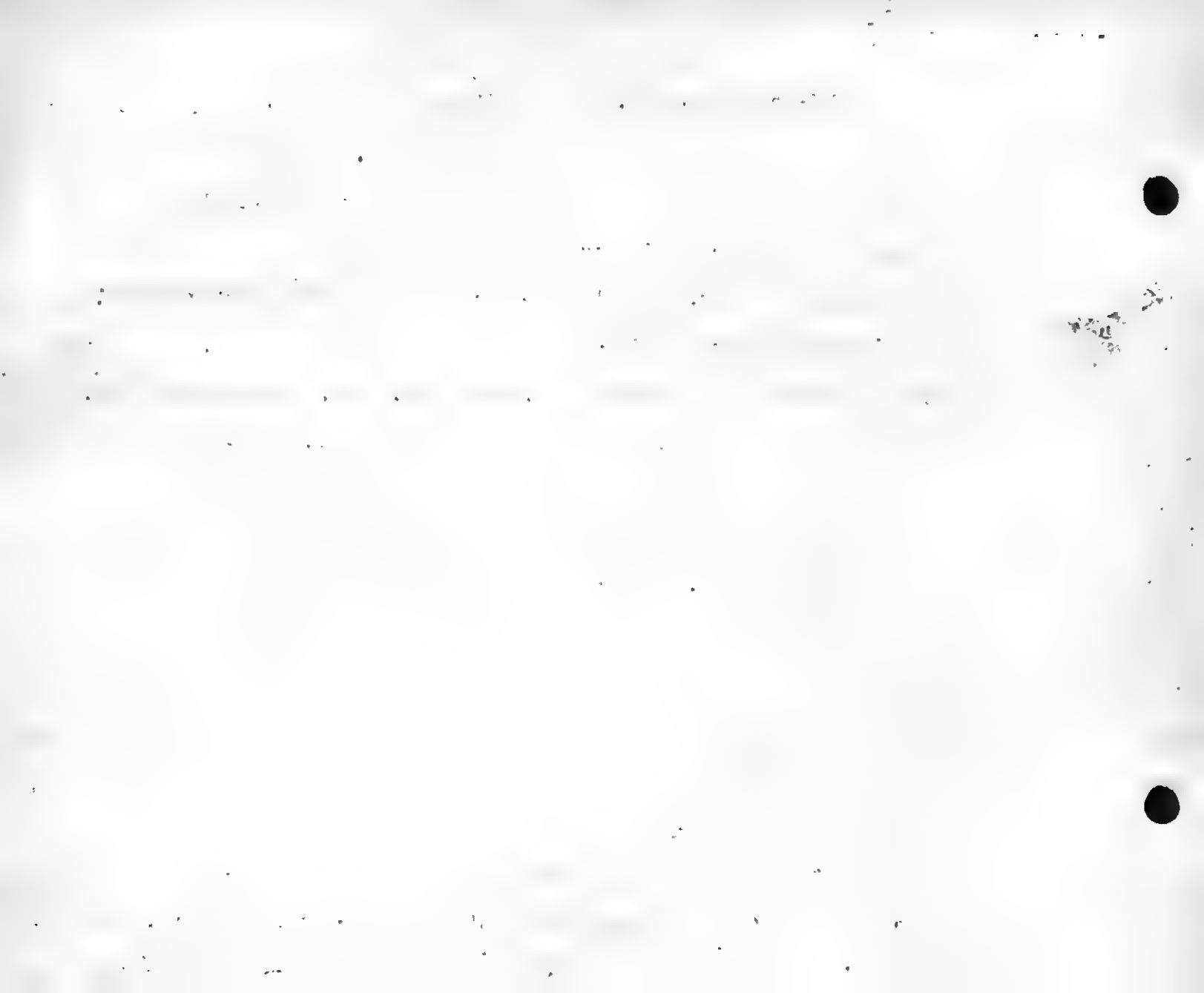


## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Glenn G. Clifton</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR <b>7:00</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>April 19, 1917</b>		6. AGE (In years last birthday) <b>51</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.	
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in home give street address) <b>Eugene Leland Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George's</b>		13c. CITY OR TOWN <b>Riverdale</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <b>William Robert</b> Middle <b>Mincey</b> Last <b>Legg</b>		15. MOTHER'S MAIDEN NAME First <b>Ora</b> Middle <b>U.</b> Last <b>Legg</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>E. Leland Mem. Hosp.</b>		18. ADDRESS <b>Riverdale, Md.</b>		19. DATE OF OPERATION <b>7-14-68</b>		20. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>↑</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour <b>A.M.</b> Month <b>July</b> Day <b>14</b> Year <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		22a. DATE SIGNED <b>7-18-68</b>	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22b. SIGNATURE <b>Lloyd H. Scribner, M.D.</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>7-14-68</b> , 19 <b>68</b> , to <b>7-18-68</b> , 19 <b>68</b> ; that (I) (we) last saw the deceased alive on <b>7-18-68</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem'l Park</b>		22d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>		22e. ADDRESS <b>831 UNIV. BLVD. E. SILVER</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem'l Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR <b>Robert P. Ware</b>		25a. REC'D BY REGISTRAR <b>JUL 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE SIGNED <b>7-18-68</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





(M) 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1134  
304 REV 1-78

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) <b>FRANK M. CLOWER</b>					2a. DATE OF DEATH Month <b>July</b> Day <b>11</b> Year <b>1968</b> 2b. HOUR <b>10</b> PM				
3 SEX <b>M</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>OCT 11, 1905</b>		6 AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>PR Geo</b>			
10 CITY OR TOWN OF DEATH <b>Cheverly Md</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PR Geo GEN</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Superintendent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTR</b>			
13a. USUAL RESIDENCE (Where deceased lived, (If institution, residence before admission) STATE <b>Md</b>		13b. COUNTY <b>PR Geo</b>		13c. CITY OR TOWN <b>College Park</b>		13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5007 Hollywood Rd</b>	
14. FATHER'S NAME First <b>HUGH</b> Middle <b>CLOWER</b> Last				15. MOTHER'S MAIDEN NAME First <b>UNKNOWN</b> Middle <b>ONEIL</b> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>579101083</b>		17 INFORMANT <b>Virginia Clower (wife)</b> Address <b>same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac Myocardial failure</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Hypertensive Encephalopathy</b> (c) <b>Hypertensive Arteriosclerotic Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>10 years</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 68</b> to <b>July 68</b> , that (I) <b>(was)</b> lost saw the deceased alive on <b>July 11</b> 19 <b>68</b> and that in (my) <b>(own)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(did)</b> view the body after death.									
22b. SIGNATURE <b>W. L. Etienne</b>				DEGREE <b>ATTENDING PHYS</b>		MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7-11-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>W. L. ETIENNE</b>				22e. ADDRESS <b>College Park Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>July 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM</b>		23d. LOCATION (City or Town) <b>COLMAR MANOR</b>		(County) <b>MARYLAND</b> (State)	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co Riverdale, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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3



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15428

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

31

1. DECEASED-NAME (Type or Print) <b>Joseph Michael Coffey</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>7-21-68</b>			2b. HOUR <b>1:31am</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>9-22-1946</b>	6. AGE (n years last birthday) <b>21</b> YRS	7. UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <b>7</b> Day <b>21</b> Year <b>68</b>			2d. HOUR <b>4:53am</b>		
7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>2900 Jennings Road</b>		
14. FATHER'S NAME First <b>Harry</b> Middle <b>J.</b> Last <b>Coffey</b>				15. MOTHER'S MAIDEN NAME First <b>Rose T.</b> Middle <b>Salvatore</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. <b>620-28-0126</b>		17. INFORMANT <b>Mar. Mary T. Coffey</b>		ADDRESS <b>" 72</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gun shot wound of abdomen</b> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. ALTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>1:30am 7-21- 19 68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Shot during altercation</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) <b>5138 Livingston Terrace</b>			21f. LOCATION Street or R.F.D. No <b>Apt. 302</b> , City or Town <b>Prince George's</b> , County <b>Prince George's</b> , State <b>Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John Kehoe</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>7-22-68</b>			
EXAMINER'S NAME (Type) <b>John Kehoe MD</b>				RIVERDALE, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE <b>July 25-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) <b>Suitland</b> , (County) <b>Maryland</b> (State)			
24. FUNERAL DIRECTOR <b>Samson Bros.</b>				ADDRESS <b>Wash. St. SE. DC</b>				25a. RECD BY REGISTRAR <b>JUL 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



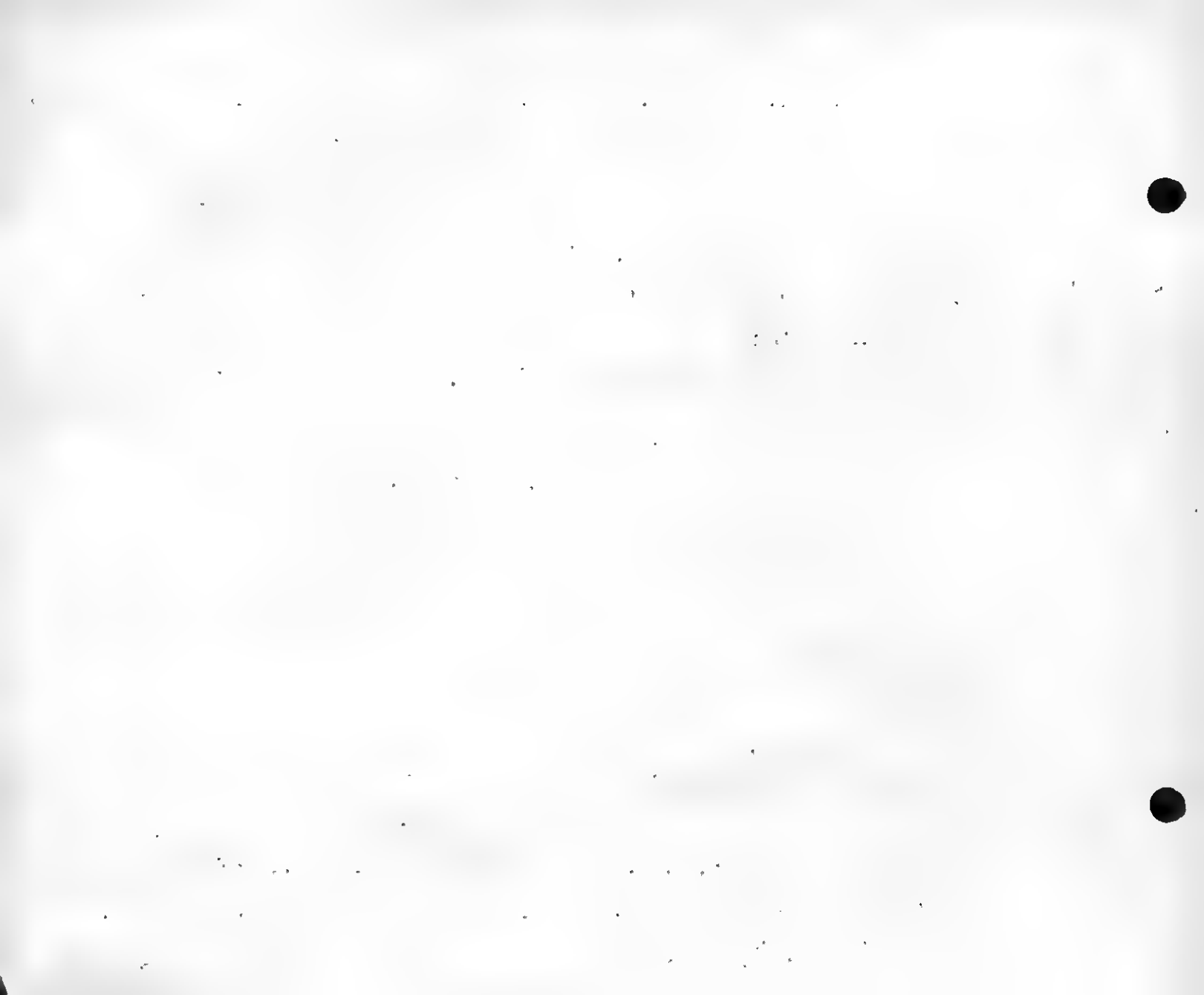
CERTIFICATE OF DEATH

10430

1. DECEASED-NAME (Type or print) <b>Norman H. Collins</b>			2a. DATE OF DEATH <b>July 31, 1968</b>			2b. HOUR <b>12:20 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>April 24, 1892</b>		6. AGE (in years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's Md</b>			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of work week, even if on leave) <b>Real Estate Broker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>--</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>7618 Marlboro Pike</b>	
14. FATHER'S NAME First Middle Last <b>Frank Collins</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Alice Harry</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>578101977</b>		17. INFORMANT <b>Edna D. Collins, Same as #13, Wife</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral metastases</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>bronchogenic Carcinoma (Right)</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) <del>(physician)</del> attended the deceased from <b>7-12-68</b> , to <b>July 31, 1968</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>July 31, 1968</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(was)</del> (did) <del>(not)</del> view the body after death.									
22b. SIGNATURE <b>Oliver Bond</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7-31-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Oliver Bond, M. D.</b>				22e. ADDRESS <b>6872 Riverdale Rd., Lanham, Maryland</b>					
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE <b>8-3-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>PG County Maryland</b>			
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b>				25a. REC'D BY REGISTRAR <b>AUG 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)						First		Middle		Last	
Horace						Conner					
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		8 IF UNDER 24 HRS	
Male		White		9-4-1930		37 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)		Tenn.		7b CITIZEN OF WHAT COUNTRY?		USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH	
								WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's Md	
10. CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly				Prince George Hospital				Repairman		Telephone	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE						13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Maryland						Prince Georges		Forest Knolls		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME						First		Middle		Last	
Clyde W. Conner											
15. MOTHER'S MAIDEN NAME						First		Middle		Last	
Kate										King	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b SOCIAL SECURITY NO		17 INFORMANT (Wife) ADDRESS			
YES						1947-55		409387290 Evelyn M. Conner, Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
176. ✓											
19a DATE OF OPERATION						19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH				2:00am 7-28-68		Shot self at home					
21d INJURY OCCURRED				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Home		Same as #13					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				John Kehoe MD		Riverdale, Md.		22b DATE SIGNED	
										7-29-68	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		7-31-68		Fort Lincoln Cenetery		PG County, Maryland					
24 FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS						25a RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
4308 Suitland Rd. SE, Suitland, Maryland						DATE		AUG 1 1968			





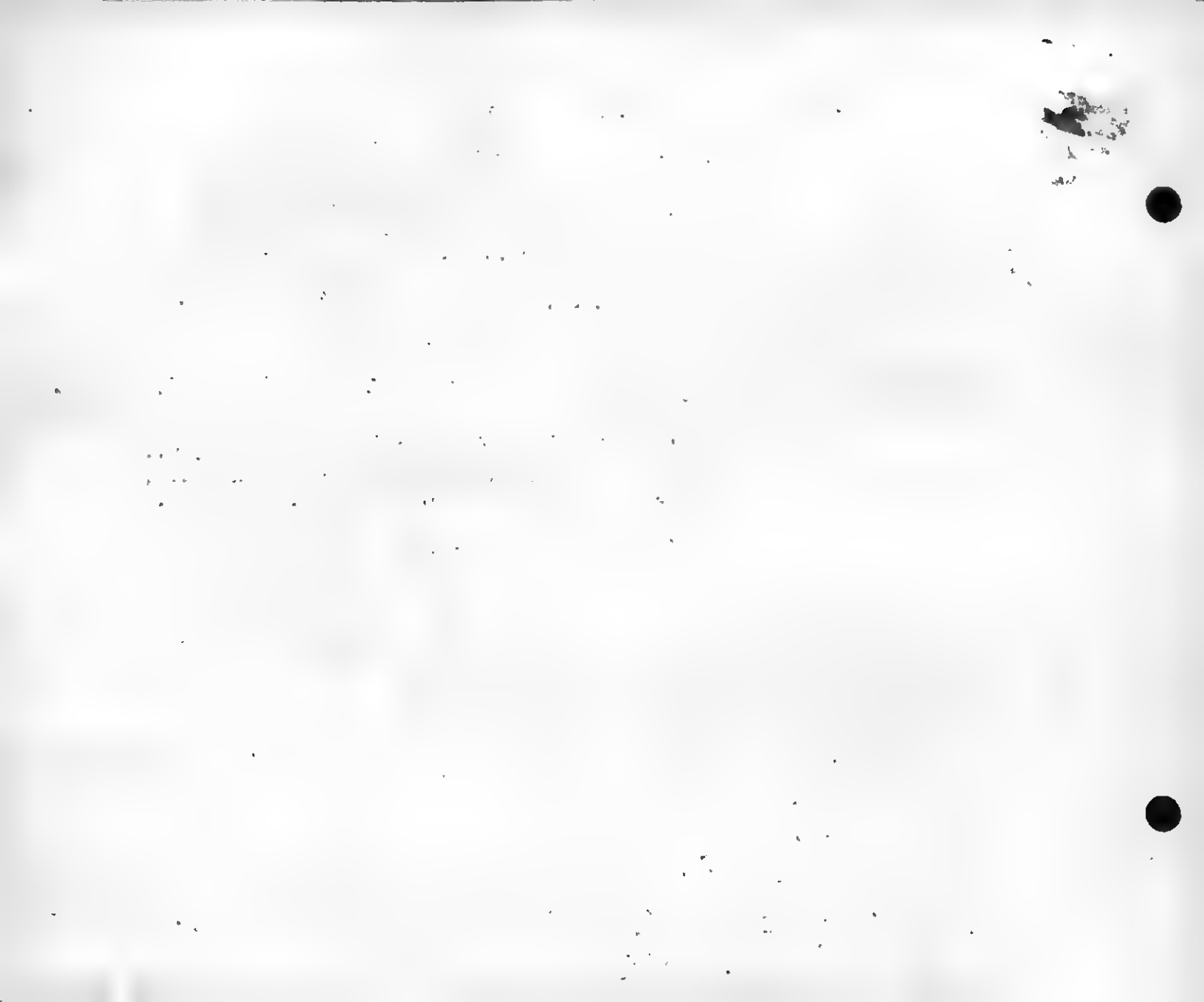




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
William				M.	Cunningham	July 20, 1968			8:25AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		Caucasian		JAN. 1, 1893		75 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			Md		
VA.		U.S.A.				Prince George's					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.			Nurse Exp.			City of Baltimore		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d. RESIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince Geo. Mt. Rainier							4108 33rd St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
THOMAS					CUNNINGHAM	UNKNOWN					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO.			17. INFORMANT			Address		
No						Richard B. BISHOP			8106 PARKBLVD FORESTVIEW, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage, right hemisphere &amp; pons.</u>											
DUE TO, OR AS A CONSEQUENCE OF <u>Bilateral confluent bronchopneumonia, pulmonary &amp; lobes, with infarction rt. lower lobe.</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
S31X											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from <u>July 2</u> , 1968, to <u>July 20</u> , 1968, that (X) (we) last saw the deceased alive on <u>July 20</u> , 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
Donald C. Edgeman M.D.			7-20-68			DONALD C. EDGEMAN			Azzatville, Md.		
23a. BURIAL (CREMATION) REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Buried		7-22-68		St. Lincoln		Columbia Manor Md					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
W.A. Chamber Co. Riverside		AUG 23 1968		J. Charles Judge							



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) <b>William Warren Curry</b>						2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>July</b> Day <b>7</b> Year <b>68</b>			2b HOUR <b>4:20</b> M <b>M</b>		
3 SEX <b>M</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>July 2, 1968</b>		6 AGE (In years last birthday) <b>5</b> YRS		IF UNDER 1 YEAR MONTHS <b>5</b> DAYS		IF UNDER 24 HRS HOURS <b>5</b> MIN	
7a BIRTHPLACE (State or foreign country) <b>Md.</b>				7b CITIZEN OF WHAT COUNTRY? <b>USA</b>				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md	
10 CITY OR TOWN OF DEATH <b>Riverdale</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Eugene L. Land Memorial</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Child</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>				13b COUNTY <b>Pr. Geo.</b>		13c CITY OR TOWN <b>Hyattsville</b>		13d INSIDE CITY, WITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>4520 Kennedy St.</b>	
14 FATHER'S NAME First <b>Douglas L.</b> Middle <b>L.</b> Last <b>Curry</b>						15. MOTHER'S MAIDEN NAME First <b>Alice</b> Middle <b>Irving</b> Last <b>Irving</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, on, or unknown) <b>NO</b>				16b SOCIAL SECURITY NO.		17 INFORMANT <b>Douglas L. Curry Father</b> ADDRESS <b>Same as above</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Atelectosis</b>										<b>Few minutes</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>SDTT</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>SDTT</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
2 a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dayton O. Watkins</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-8-68				22b DATE SIGNED			
EXAMINER'S NAME (Type) <b>Dayton O. Watkins</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town or county) <b>5318 Annapolis Rd., Bladensburg, Md.</b>			
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>7/10/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>				23d LOCATION (City or Town) <b>COLMAR MANOR</b> (County) <b>MARYLAND</b> (State)			
24 FUNERAL DIRECTOR <b>F. GASCH'S SONS</b> ADDRESS <b>HYATTSVILLE, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>				25b REGISTRAR'S SIGNATURE <b>J. Charles Jones</b>			

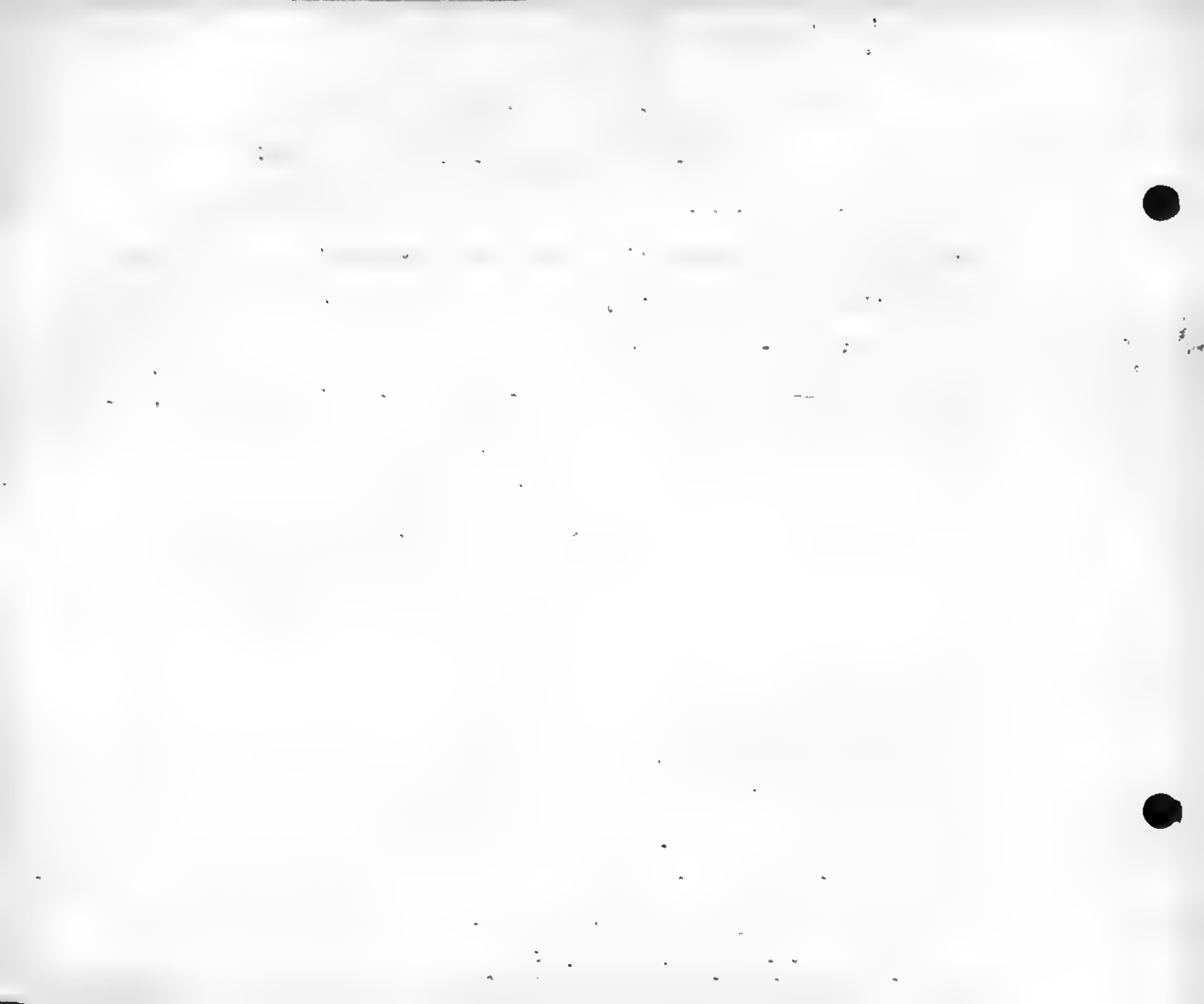


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <i>Mary</i> <sup>First</sup> <i>H.</i> <sup>Middle</sup> <i>Davis</i> <sup>Last</sup>			2a. DATE OF DEATH <i>July</i> <sup>Month</sup> <i>14</i> <sup>Day</sup> <i>1968</i> <sup>Year</sup>		2b. HOUR <i>10:55</i> <sup>PM</sup>						
3. SEX <i>Female</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>Nov. 6, 1885</i>		6. AGE (In years last birthday) <i>82</i> YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN	
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		7b. CIT. ZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George</i>					
10. CITY OR TOWN OF DEATH <i>Hyattsville</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hyattsville Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institut on- Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Hyattsville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>814 Rittenhouse Street</i>			
14. FATHER'S NAME First <i>David</i> Middle <i>-</i> Last <i>Davies</i>			15. MOTHER'S MAIDEN NAME First <i>Catherine</i> Middle <i>-</i> Last <i>(Unknown)</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>yes</i>		17. INFORMANT <i>Mr. Raymond W. Davis</i>			2224 <i>Charleston Place</i> <i>Hyattsville, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>400 X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) <i>senility</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertensive heart disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4431</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>5-30, 1968</i> to <i>7-14, 1968</i> , that (I) (we) lost the deceased alive on <i>7-13, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.											
22b. SIGNATURE <i>M. Snow MD</i>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7-14-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Dr. Margaret J. Snow</i>				22e. ADDRESS <i>9013 Flower Avenue, Silver Spring, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>July 17, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>					
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>434 Georgia Avenue</i>		25a. REC'D BY REG. STRAR DATE <i>JUL 19 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Yung</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
Item #6, Film 403 8/1/68 km			1. DECEASED-NAME (Type or print)			2a. DATE OF DEATH			2b. HOUR		
First Middle Last			James E. Dent			Month Day Year			7 28 68		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
Male			Negro			5-8-08			60 759 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
D.C.			USA						Prince George's Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			DOA-Prince Geo. Gen'l Hospital			Laborer			County		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Forrestville			8611 West Phalia Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Arthur Dent			Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
no			579-14-6973			Wife			8611 westphalia rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Metastatic Carcinoma to liver										3 mos	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151X											
(b) Carcinoma of Stomach										6 mos	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Coronary Heart Disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from July 1967, to 7/28, 1968, that (I) (we) saw the deceased alive on 7/28/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
Henry A. Wise			7/29/68								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Henry A. Nise, Jr.			9005 Volta St. Lanham Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			7-31-68			St. Luke's Cemetery			Meadows, Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Rollins, Inc. 4339 Hunt Pl., N.E., DC			JUL 30 1968			Charles Young					



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>10436</div> <div>Item#5, Film G40388/1/68 km</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div>											
1. DECEASED NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
Woodie C Dowell						Month July Day 20 Year 1968			12.01 AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		1 Sept., 1918 17		50 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		US A				Pr. Geo. Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Pr. Geo., Gen., Hosp.,			Painter					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY, IN 1ST YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Pr. Geo.,			Beltsville				4519 Powder Mill Rd.	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
First Middle Last				First Middle Last							
Walter Dowell				Margaret Christin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes W W 11				577 28 7727		Bernice Dowell Beltsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1 DEATH CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Bronchopneumonia right upper lobe.</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Bronchiogenic carcinoma, right upper lobe</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>metastatic carcinoma to liver, kidneys, spleen.</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Bilateral pulmonary emphysema &amp; edema.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 14</u> , 19 <u>68</u> , to <u>July 21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>July 21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<u>Till Bergman</u>										<u>July 21 1968</u>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Till Bergman						Greenbelt, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATOR				23d. LOCATION (City or Town) (County) (State)			
Burial		7/24/68		Ft Lincoln Cemetery				Colmar Manor Pr Geo Md.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hya ttsville, Md.				DATE JUL 26 1968		<u>J Charles Judge</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Helen K. Downes</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1968</b>			2b. HOUR <b>12:15</b> M			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>8/30/1899</b>		6 AGE (In years last birthday) <b>68</b> YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md.			
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6170 Princess Garden Pkwy.</b>	
14 FATHER'S NAME First Middle Last <b>Walter Warren Brines</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Violetta Smith</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17 INFORMANT <b>Richard Downes</b>		Address <b>Lanham Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>4350</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension, essential</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) <del>physician</del> attended the deceased from <b>July 19, 1968</b> , to <b>July 19, 1968</b> , that (I) <del>last</del> saw the deceased alive on <b>July 19, 1968</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>Donald C. Edgeman</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7-20-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>DONALD C. EDGEMAN</b>		22e. ADDRESS <b>Prince George's Plaza, Hyattsville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL, ETC. <b>Buried</b>		23b. DATE <b>July 22, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Thomas Episcopal</b>		23d. LOCATION (City or Town) (County) <b>Croom Pro Geo Md.</b>		20783 (State)	
24. FUNERAL DIRECTOR ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year			2b HOUR 45 A. M.	
Sylvene R. Dreyer									- July 21 68			5 45 A. M.	
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (in years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN.	
Female		white		MARCH 13, 1879				89 YRS					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH				
Baltimore Md			U. S. A.						Prince Georges Md				
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Hyattsville, Md				Hyattsville Nursing Home				Housewife					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE				13b COUNTY				13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland				Prince Georges				Riverdale		YES <input type="checkbox"/> NO <input type="checkbox"/>		5005 Oakthorpe	
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME			First Middle Last	
William							Reiser		Magdalene			Hentner	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No (If yes give war or dates of service)				16b SOCIAL SECURITY NO				17 INFORMANT				Address	
No				219-54-9365				Dreyer, Carolee				630 Sheridan St Hyattsville, Md	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4369 Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 331X												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hrs. 10 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Recurrent cystitis & pyelonephritis.													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (1) (this hospital) attended the deceased from 4-28, 1967, to 7-21, 1968, that (1) (we) last saw the deceased alive on 7-20, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (I) (did not) view the body after death													
22b SIGNATURE R.D. Bauer M.D.								DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 7-21-68	
22d PHYSICIAN'S NAME (Type) R.D. Bauer, M.D.								22e ADDRESS 2513 Buck Lodge Rd - Maple, P.O. Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Burial			July 24, 1968			Rock Creek Cemetery			Washington, D.C.				
24 FUNERAL DIRECTOR Glen Carter, Inc. 434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.								25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE Charles Judge			
								DATE JUL 25 1968					





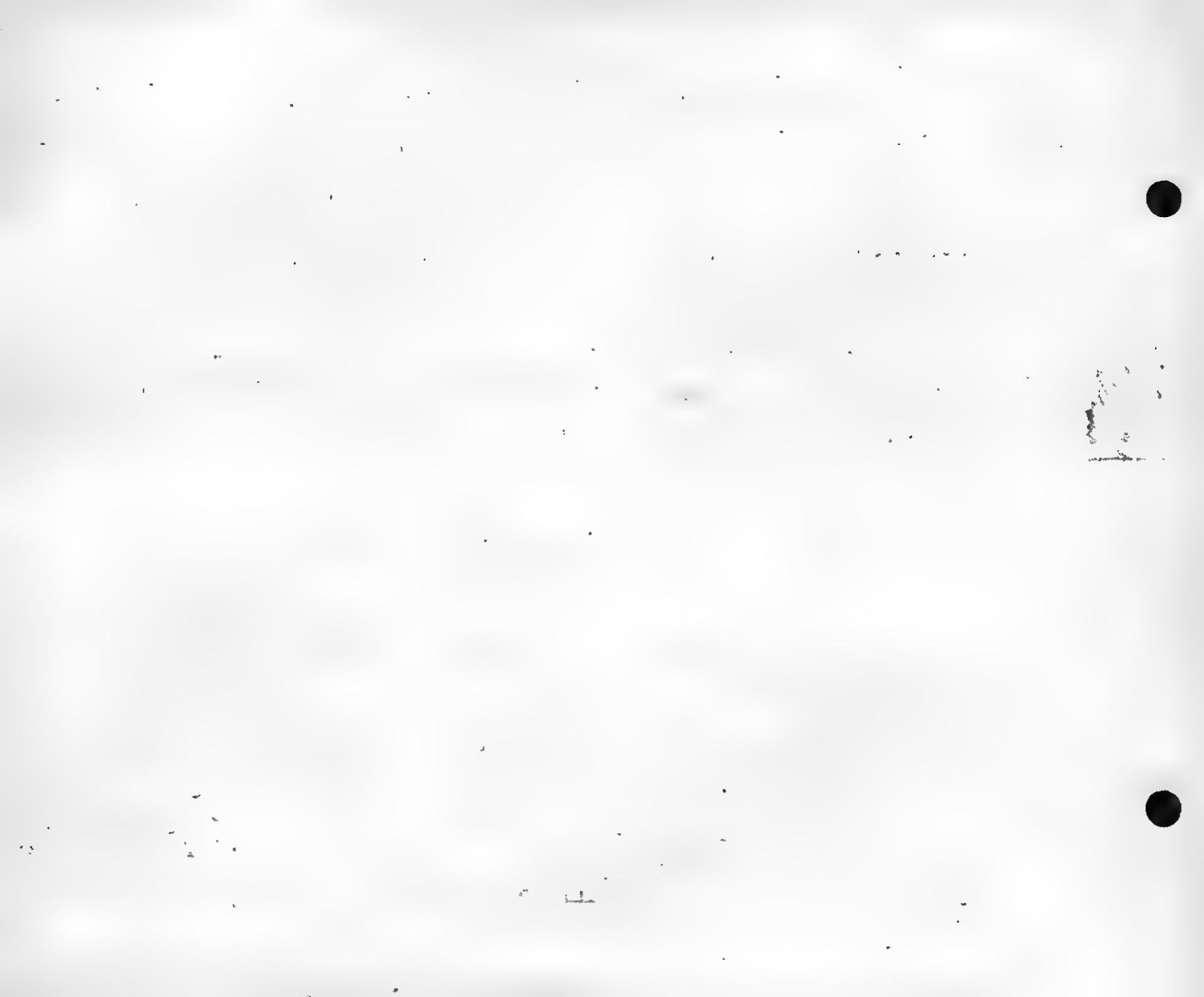
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>NEWBORN</b>			First <b>DOUGLAS</b> Middle <b>DEAN</b> Last <b>DYER</b>			2a. DATE OF DEATH Month <b>JUL</b> Day <b>28</b> Year <b>68</b>			2b. HOUR <b>4:00</b> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>		
3 SEX <b>MALE</b>			4 RACE <b>CAUC</b>			5. DATE OF BIRTH <b>27 JUL 68</b>			6 AGE (In years last birthday) YRS <b>1</b> MONTHS <b>2</b> DAYS <b>31</b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince Georges</b> Md		
10. CITY OR TOWN OF DEATH <b>Camp Springs</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Malcom Grow USAF Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUS.NESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Prince Georges</b>			13c. CITY OR TOWN <b>Forrestville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>7435 Keystone Lane</b>			14. FATHER'S NAME First <b>TERRY</b> Middle <b>GENE</b> Last <b>DYER</b>			15. MOTHER'S MAIDEN NAME First <b>MINNIE</b> Middle <b>LOIS</b> Last <b>ODAM</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>			16b. SOCIAL SECURITY NO <b>na</b>			17 INFORMANT <b>FORESTVILLE MD</b>			17b. ADDRESS <b>TERRY G DYER 7435 KEYSTONE LN #102</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Respiratory Distress Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 hr</b> <b>1 hr</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>27 Jul</b> , 19 <b>68</b> , to <b>28 Jul</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>28 Jul</b> , 19 <b>68</b> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (do) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <b>Paul H. Kerner M.D.</b>			22c. DATE SIGNED <b>28 July</b>			22d. PHYSICIAN'S NAME (Type) <b>PAUL H. KERNER M.D.</b>			22e. ADDRESS <b>USAF HOSP Andrews.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>8/9/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Washington D.C.</b>			23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>		
24. FUNERAL DIRECTOR <b>Paul F. Schubert</b>			25a. REC'D BY REGISTRAR <b>AUG 1 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



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20440

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When these remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>NEWBORN</b>			First <b>JAMMIE</b> Middle <b>JEAN</b> Last <b>DYER</b>			2a DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>1968</b>			2b HOUR <b>0429</b> M		
3 SEX <b>FEMALE</b>			4 RACE <b>Ca.</b>			5 DATE OF BIRTH <b>27 July 1968</b>			6 AGE (In years last birthday) YRS <b>14</b> MONTHS <b>29</b> DAYS <b>14</b>		
7a BIRTHPLACE (State or foreign) <b>Maryland</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>PRINCE GEORGE'S</b>		
10 CITY OR TOWN OF DEATH <b>Andrews AFB</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Matilda Grow USAFHosp</b>			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b COUNTY <b>Prince Georges</b>			13c CITY OR TOWN <b>Forrestville</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET AND NUMBER <b>7435 Keystone Lane</b>			14 FATHER'S NAME First <b>TERRY</b> Middle <b>GENE</b> Last <b>DYER</b>			15 MOTHER'S MAIDEN NAME First <b>MINNIE</b> Middle <b>LOIS</b> Last <b>ODAM</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO			17 INFORMANT <b>FORESTVILLE MD</b> Address <b>#102 TERRY G DYER 7435 KEYSTONE LN #XXX</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory &amp; Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Prematurity</b> <b>Respiratory Distress Synd.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Premature Birth</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>14 hrs 28 min</b> <b>14 hrs 28 min</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b>1</b> Month <b>7</b> Day <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>27 Jul</b> , 19 <b>68</b> , to <b>28 Jul</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>28 Jul</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Paul H. Penzer MD</b>			DEGREE <b>MD</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>28 July</b>		
22d. PHYSICIAN'S NAME (Type) <b>PAUL H. PENZER MD</b>			22e. ADDRESS <b>USAF Hosp. Andrews</b>								
23a. CREMATION, <input checked="" type="checkbox"/> BURIAL (Specify)			23b. DATE <b>28 8/9/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Washington D.C. Christian</b>			23d. LOCATION (City or Town) (County) (State) <b>Washington D.C.</b>		
24. FUNERAL DIRECTOR <b>Carl F. Penzer</b>			ADDRESS			25a. REC'D BY REGISTRAR <b>AUG 1 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

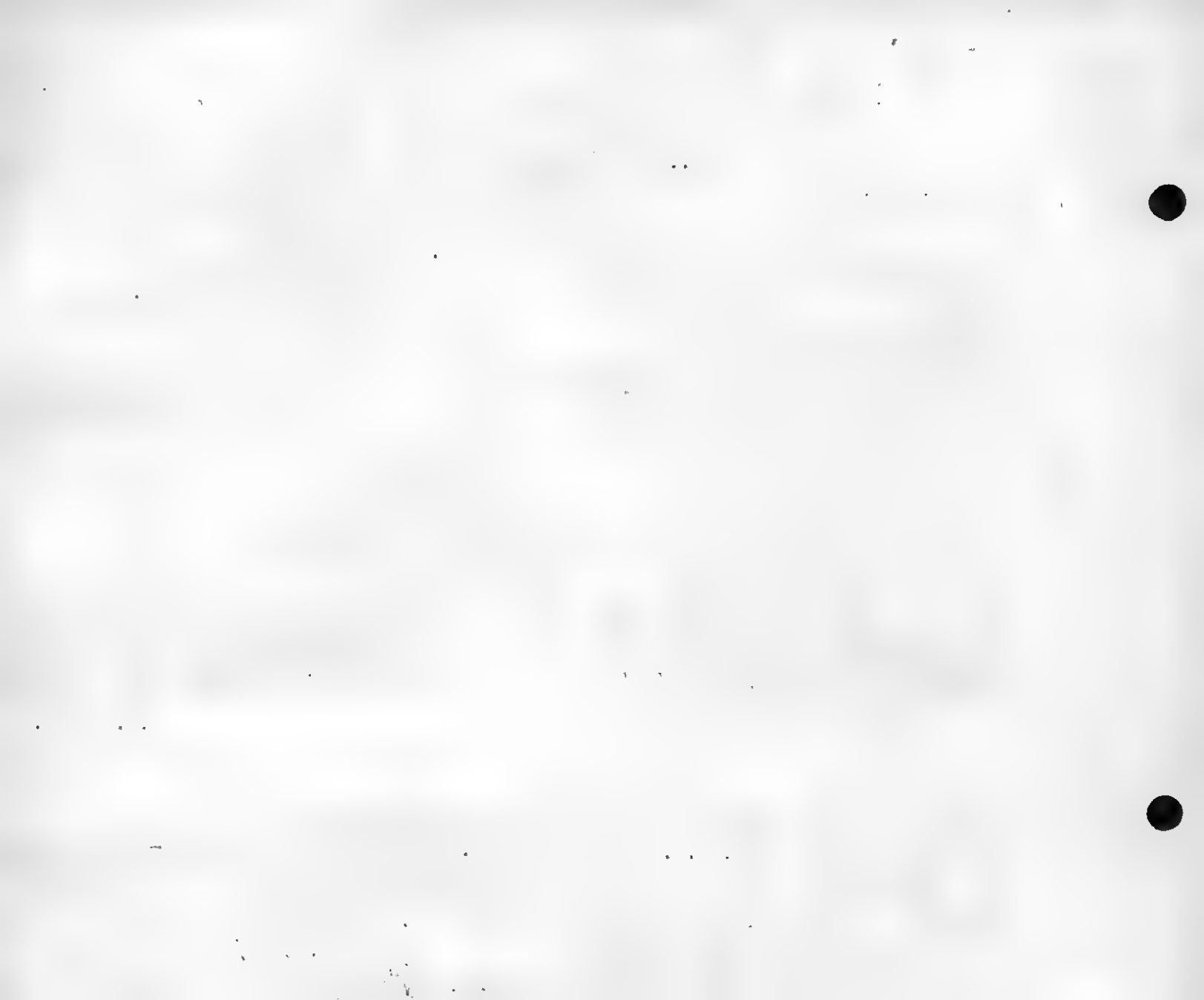


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <i>Johnathan Reid Fauntleroy</i>						2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> <i>9 9 1968</i>		2b HOUR <i>3:00 a.m.</i>			
3 SEX <i>M</i>		4 RACE <i>W</i>		5. DATE OF BIRTH <i>21 Jan., 1953 15 YRS</i>		6 AGE (In years last birthday) <i>15</i>		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>California</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Prince George</i>		2c DATE PRONOUNCED DEAD Month <i>7</i> Day <i>9</i> Year <i>68</i>		2d HOUR <i>Same</i>	
10 CITY OR TOWN OF DEATH <i>Forestville</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Andrews Air Force Hosp.</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Student</i>		12b KIND OF BUSINESS OR INDUSTRY <i>School</i>	
13a USUAL RESIDENCE (Where deceased lived (admission) STATE <i>Md</i>				13b COUNTY <i>Baltimore</i>		13c CITY OR TOWN <i>Baltimore</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>703 Anneslie Rd.</i>	
14 FATHER'S NAME First <i>William</i> Middle <i>Reid</i> Last <i>Fauntleroy</i>						15. MOTHER'S MAIDEN NAME First <i>Beirdre</i> Middle <i>Ann</i> Last <i>Holdsworth</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b SOCIAL SECURITY NO. <i>219-56-2700</i>		17 INFORMANT <i>Mother</i>		ADDRESS <i>Same as above</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intoxication</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Colchicine</i> (b) <i>Colchicine</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>9718</i>											
19a DATE OF OPERATION <i>7-9-68</i>				19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Drank solution of colchicine</i>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year <i>7:99 P.M. 7 7 1968</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item .B.) <i>Drank solution of colchicine</i>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Edgemoor School</i>		21f LOCATION Street or R.F.D. No <i>Rt 301</i>		City or Town <i>Clinton</i>		County <i>P.G.</i>		State <i>Md.</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Kehoe</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>7-9-68</i>			
EXAMINER'S NAME (Type) <i>John Kehoe, M.D., Riverdale, Md</i>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <i>Charles Judge</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 11, 1968</i>		23c NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem</i>		23d LOCATION (City or Town) <i>Catonsville, Maryland</i>		(County) <i></i>		(State) <i></i>	
24. FUNERAL DIRECTOR <i>John Burns' Sons, Towson, Maryland</i>				25a REC'D BY REGISTRAR <i>JUL 15 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>Queenie A. FERGUSON</b>			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
3 SEX <b>F</b>			4 RACE <b>NE GRO</b>			5 DATE OF BIRTH <b>SEPT 12, 1893</b>			6 AGE (In years last birthday) <b>84 YRS.</b>		
7a. BIRTHPLACE (State or foreign country) <b>S. CAROLINA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Hyattsville Nursing Home; 6500 RIGGS RD.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>D.C.</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>WASHINGTON</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		
17 INFORMANT Address			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST - ASPIRATION</b> <b>150 X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF THE ESOPHAGUS</b> <b>150 X</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>150 X</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 MINS.</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>LAENERS CIRCROSIS; CARDIOMEGALY; PULM EMBOLISM.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY 8, 1968</b> , to <b>JULY 10, 1968</b> , that (I) (we) last saw the deceased alive on <b>JULY 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Harold W. Draper M.D.</b>			22c. PHYSICIAN'S NAME (Type) <b>HAROLD W. DRAPER M.D.</b>			22d. ADDRESS <b>9801 GEORGIA AVE. SILVER SPRING MD.</b>			22e. DATE SIGNED <b>July 10, 68</b>		
23a. B. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>7/14/1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>SOAP STONE CHURCH CEMETERY GREENVILLE</b>			23d. LOCATION (City or Town) (County) (State) <b>S. Car</b>		
24. FUNERAL DIRECTOR <b>William Spangler</b>			ADDRESS <b>WASH D.C.</b>			25a. REC'D BY REGISTRAR <b>JUL 15 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>		



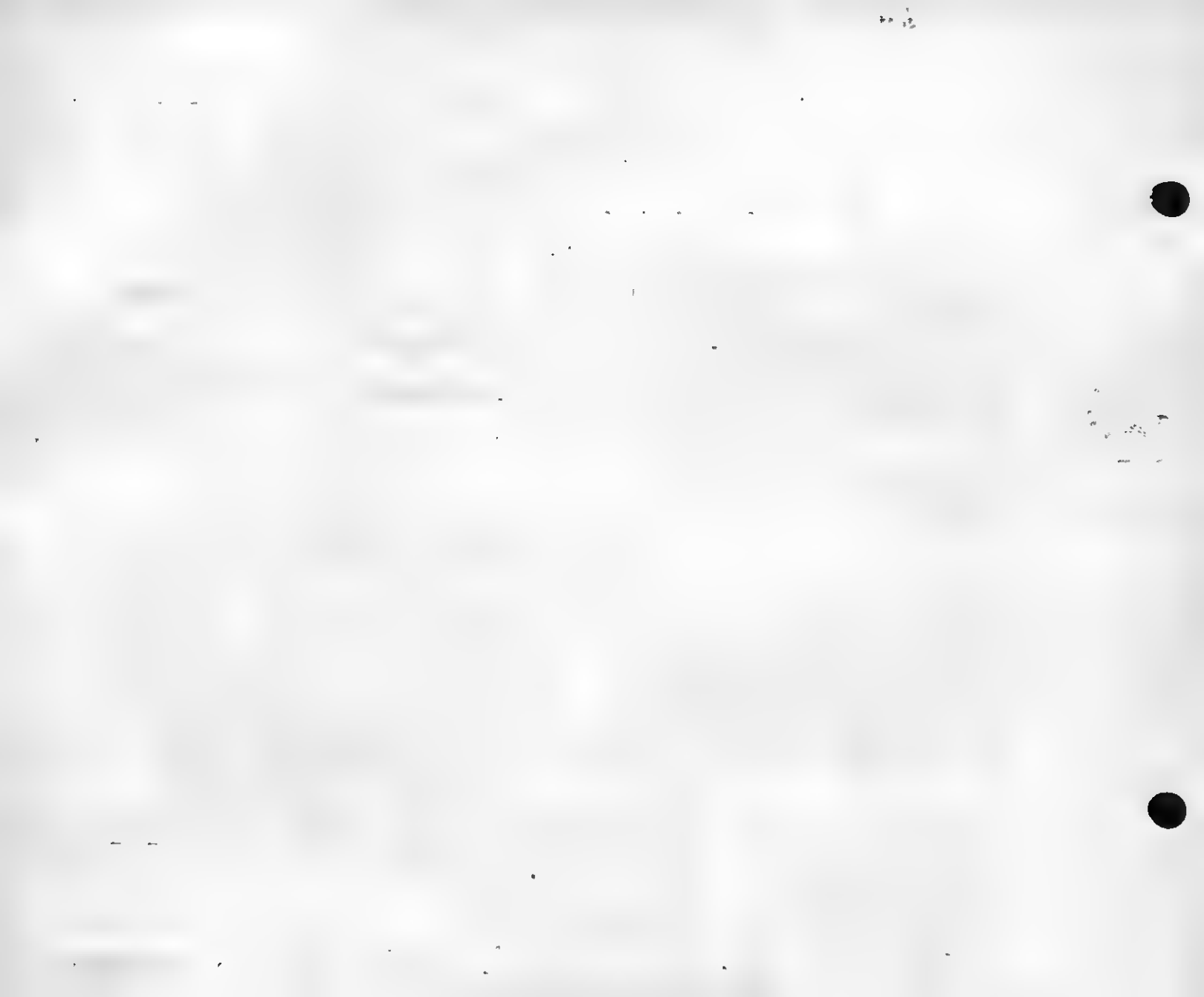


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. Any delays necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item 5, 6, 8 Film 3403 8 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) First Middle Last <b>Adeline Bonn Fickus</b>						2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>7-20-68 19 6</b>			2b HOUR <b>00pm</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>29 March 1895</b>		6 AGE <b>73</b> YEARS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD Month Day Year <b>20 68 7:30pm M</b>	
7a. BIRTHPLACE (State or foreign country) <b>Scranton, Penn.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's Md</b>			
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hyattsville Nursing Home</b>				12a. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9324 Alcona Street</b>	
14 FATHER'S NAME First Middle Last <b>Adam L. Bonn</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Henrietta Schumacher</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16b. SOCIAL SECURITY NO <b>yes</b>		17 INFORMANT <b>Mrs. Adelaide Jones Lanham, Maryland</b>			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Malignant glioma, right temporal</b> <b>11x1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>over 6 mo.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>11x1</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe MD</b>		RIVERDALE, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>July 23, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dunmore Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Dunmore, Pennsylvania</b>		25a. RECD BY REG. STRAR <b>JUL 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Wagner &amp; Humphrey, Inc.</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

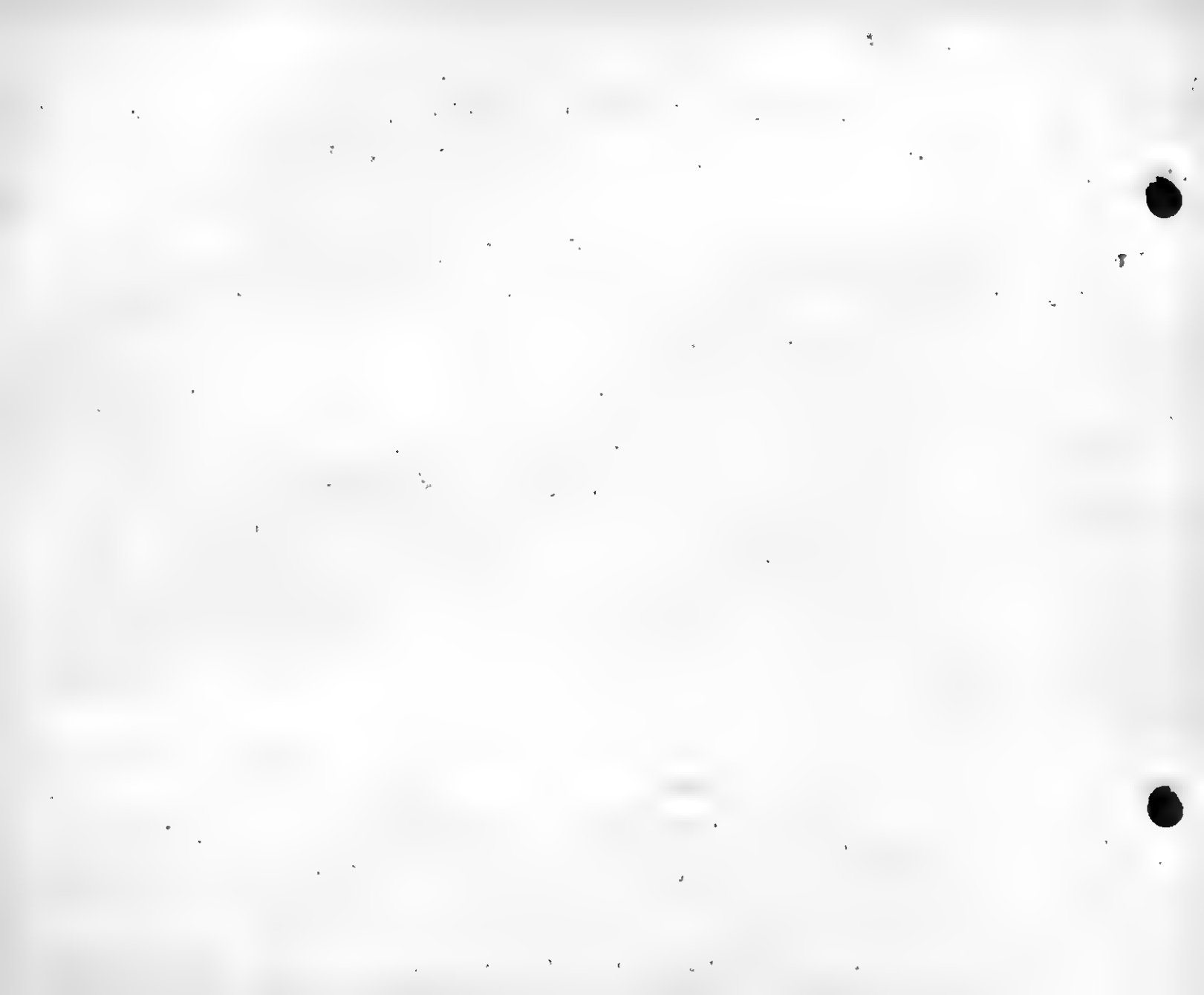
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)		CATHERINE <i>Katherine</i>		Middle E.		Last Fischer		2a DATE OF DEATH Month Day Year July 22, 1968		2b. HOUR 1:55 AM	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 12/9/1881		6 AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) DC		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md					
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hosp.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Midwife		12b. KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Seat Pleasant		13d INSIDE CITY, J.M.T? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 600 Addison Road			
14. FATHER'S NAME First Middle Last Oliver J. Preston		15 MOTHER'S MAIDEN NAME First Middle Last Margaret Shugroo									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO. 579017404		17. INFORMANT (Son) Address Oliver Fischer, 6807 Randolph St, Landover, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe obstructive jaundice</i> <i>1570</i> DUE TO, OR AS A CONSEQUENCE OF <i>pan carcinoma of the head of the pancreas</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>arterio-sclerosis heart disease</i>											
9a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) <del>did not</del> attended the deceased from <i>7/13/68</i> , 19 <i>68</i> , to <i>July 22</i> , 19 <i>68</i> , that (I) <i>did</i> last saw the deceased alive on <i>July 21</i> , 19 <i>68</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> (did not) view the body after death											
22b SIGNATURE <i>Elie A. Sayan MD</i>		DEGREE MD		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 7/24/68			
22d. PHYSICIAN'S NAME (Type) ELIE A. SAYAN		22e ADDRESS 5803 Landover Rd Cheverly Md									
23a. BURIAL, CREMATION (Specify)		23b DATE 7-25-68		23c NAME OF CEMETERY OR CREMATORY Glennwood Cemetery		23d LOCATION (City or Town) (County) (State) Washington, D.C.					
24. FUNERAL DIRECTOR <i>Wilhelm Funerals Home</i>		ADDRESS <i>Switzland, MARYLAND</i>		25a REC'D BY REGISTRAR DATE JUL 29 1968		25b REGISTRAR'S SIGNATURE <i>Charles Jones</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <i>Malcolm Francis Freshman</i>					2a. DATE OF DEATH Month Day Year <i>7 27 1968</i>			2b. HOUR <i>9:25</i> M	
3 SEX <i>Male</i>		4 RACE <i>white</i>		5. DATE OF BIRTH <i>Sept 18, 1915</i>		6. AGE (In years last birthday) <i>52</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's</i> Md			
10. CITY OR TOWN OF DEATH <i>Lanham, Md</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>6302-93th ave</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <i>Fuel oil dealer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>self</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Pro Georges</i>		13c. CITY OR TOWN <i>Lanham</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>6302 93th avenue</i>	
14. FATHER'S NAME First Middle Last <i>Francis Levi Freshman</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Rose R Simpson</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <i>217 01 6009</i>		17. INFORMANT <i>Label I Freshman</i>		Address <i>Lanham, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cancer Right Lung</i> (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several months</i> <i>1 year</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>None</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 1967, to <i>7/27</i> , 1968, that (I) <del>(was)</del> last saw the deceased alive on <i>7/27</i> , 1968, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(was)</del> (did) <del>(did not)</del> view the body after death.									
22b. SIGNATURE <i>James Kurtz MD</i>				DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7/27/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Dr James Kurtz</i>				22e. ADDRESS <i>R.F.D. Glenn Dale Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 30, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Colmar Manor Pro Geo Md.</i>			
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>				ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR <i>AUG 1 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Frances D. Forbes						July 2 68			1325M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Female		Caucasian		14 Dec 23		44 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		USA				Prince George's County Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Andrews AFB			Malcolm Grow USAF Hosp			Housewife					
13a. USAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md			Prince Georges		Oxon Hill		X		217 Panorama Dr		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Lloyd Calvin Davis						Mary Slater					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT			Address
No						263-40-6002		Husband			Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho pneumonia, septicemia, pyelonephritis</u>											
174X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebra</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Metastatic Brain Tumor, 10 @ Breast.</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
170X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)			21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from 1 May, 1968, to 2 Jul, 1968, that (I) (we) last saw the deceased alive on 2 Jul, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John F. Lindeman</u>						DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) JOHN F. LINDEMAN, CAPT, USAF						22e. ADDRESS		AFB, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
			7/5/68		Tabernacle Mem. Cem		New Kent County Va				
24. FUNERAL DIRECTOR			ADDRESS		25a. REC'D BY REG STRAR		25b. REGISTRAR'S SIGNATURE				
W. Chambers Co			1400 Chapin St		MD - 9 1968		Charles Judge				





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Rose S. Forkish</b>			2a. DATE OF DEATH Month <u>7</u> Day <u>23</u> Year <u>68</u>			2b. HOUR <u>7:30 A</u> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12/8/05</b>		6. AGE (In years last birthday) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u> HOURS <u>  </u> MIN. <u>  </u>	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Gen. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>12400 Ryland Ct.</b>	
14. FATHER'S NAME First Middle Last <b>Kalman Ferster</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ida Gross</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT <b>Max Flrkish</b>		Address <b>Bowie, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>4/10/68</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus Cognitive Heart Failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 16, 1968</u> , to <u>July 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>23 July</u> 19 <u>68</u> , and that in my(our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert Deitz, M.D.</u>				DEGREE <u>M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/22/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Robert Deitz, M.D.</b>				22e. ADDRESS <b>Prince George's Plaza, Hyattsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 25, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>			
24. FUNERAL DIRECTOR <b>P. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 26 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

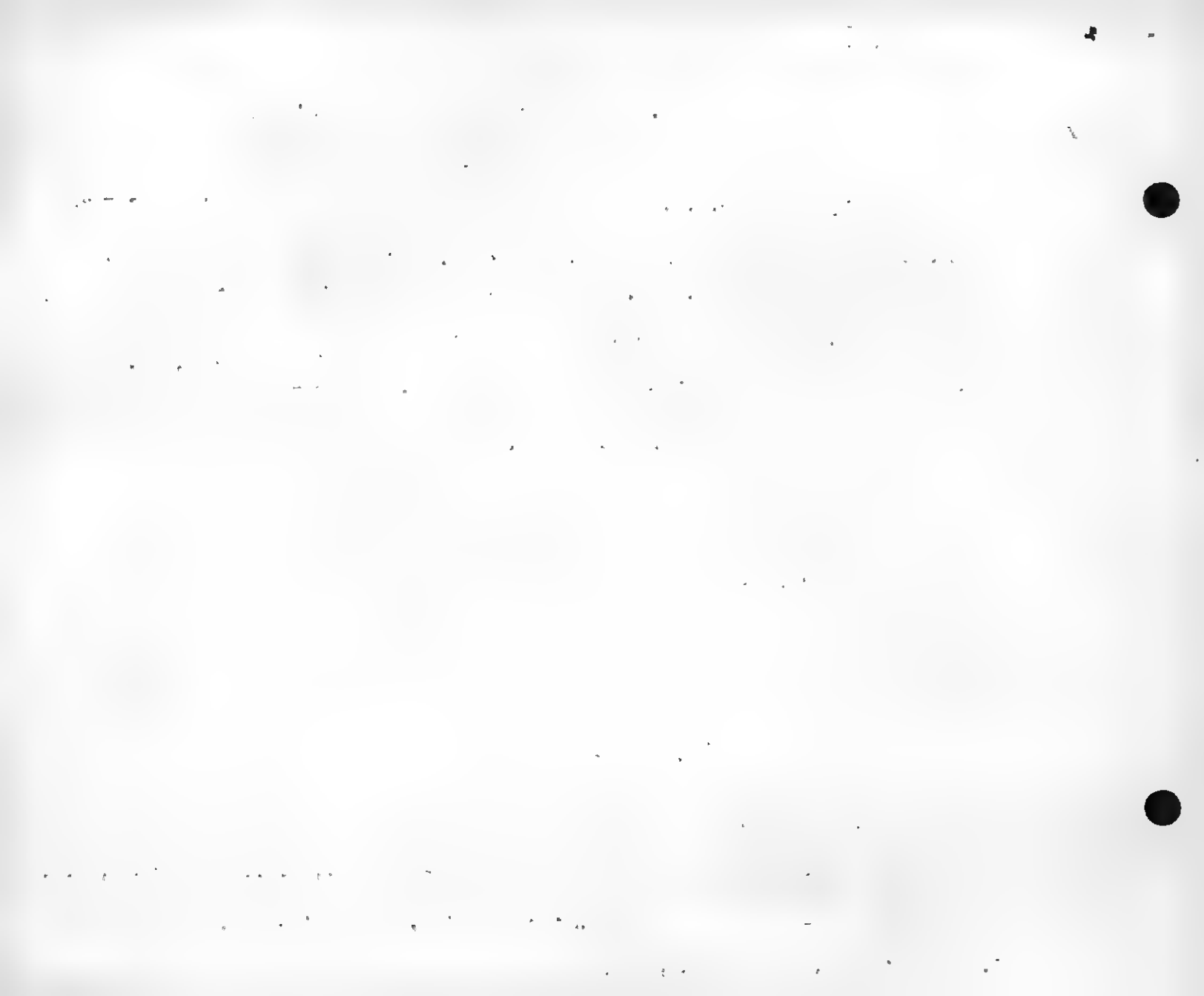
1 DECEASED NAME (Type or print) <b>Gladys</b>			First Middle Last			2a. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1968</b>			2b HOUR <b>5:32 AM</b>		
3 SEX <b>Female</b>			4 RACE <b>Caucasian</b>			5 DATE OF BIRTH <b>11/10/98</b>			6 AGE (In years last birthday) <b>69</b> YRS		
7a BIRTHPLACE (State or foreign country) <b>W. VA.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Prince George's</b> Mo		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>AT HOME</b>			12b KIND OF BUSINESS OR INDUSTRY <b>HOME MAKER</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE <b>Maryland</b>			13b COUNTY <b>Prince George's</b>			13c CITY OR TOWN <b>Clinton</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER <b>6001 Woodland Rd.</b>			14. FATHER'S NAME First Middle Last <b>UNKNOWN COX</b>			15. MOTHER'S M.A.DEN NAME First Middle Last <b>UNKNOWN FISHER</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>NONE</b>			17 INFORMANT Address <b>RAYMOND POST, JR. 204 W. ANOAK ST. DULUTH, MINN.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic cardiovascular disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>T.T.T.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>July 30</b> , 1968, to <b>July 31</b> , 1968, that <b>he</b> (we) last saw the deceased alive on <b>July 31</b> , 1968, and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) <b>did not</b> view the body after death.											
22b SIGNATURE <b>W. W. Chambers, M.D.</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <b>W. W. CHAMBERS</b>						22e. ADDRESS <b>Prince George's General Hospital, Cheverly</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b DATE <b>8/3/68</b>			23c NAME OF CEMETERY OR CREMATORY <b>WHITFIELD CHAPEL CEM. LANHAM</b>			23d LOCATION (City or Town) (County) <b>PR. GEO. MD. Maryland</b>		
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS</b>						ADDRESS <b>60501 CLEVELAND RIVERDALE</b>			25a REC'D BY REGISTRAR DATE <b>AUG 6 1968</b>		
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Allen			S. Freeze			July 5, 1968			7:40 p.m.
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male	White		02-01-08			60 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
West Virginia		U.S.A.				Prince Georges Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hospt.			Repairman			C&P Telephone
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Pr. Geo.		Cheverly	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6215 Forrest Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Willis Freeze			Bessie Yountz						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT				
			577-01-0099		Catherine C. Freeze - 6215 Forrest Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Esophagus branched fistula</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1968, to <u>July 5</u> , 1968, that (I) (we) last saw the deceased alive on <u>July 5 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>George William Ware</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED		
							7-6-68		
22d. PHYSICIAN'S NAME (Type) George William Ware					22e. ADDRESS				
					1835 - I - St., N.W., Washington, D.C.				
23a B. RIAL, CREMAT. ON, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		7-8-68		Resurrection Cemetery		Clinton, Pr. Geo., Maryland			
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
F. Gasch & Sons, Hyattsville, Maryland					DATE JUL - 8 1968		<u>J. Charles Judge</u>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-155 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

## Item 22a film 403 8-5-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 0450 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>Timothy Joseph Frye Jr.</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>7-21-68</b> 194: <b>34</b> PM				2b. HOUR	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>2-22-1926</b>	6 AGE (In years last birthday) <b>42</b> YRS	7 UNDER 1 YEAR MONTHS _____ DAYS _____	7 UNDER 24 HRS HOURS _____ MIN _____	2c. DATE PRONOUNCED DEAD Month <b>7</b> Day <b>21</b> Year <b>68</b> 197: <b>00</b> PM			2d. HOUR
7a. BIRTHPLACE (State or foreign country) <b>Washington D C</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5407 38th. Avenue</b>	
14. FATHER'S NAME First Middle Last <b>Timothy Joseph Frye Sr</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Dorothy C Mc Gill</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>yes</b> (If yes give war or dates of service) <b>W W II</b>			16b. SOCIAL SECURITY NO. <b>577 28 9296</b>		17. INFORMANT ADDRESS <b>Timothy J Frye sr Hyattsville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> <b>924X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1268</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>4:34pm</b> <b>7-21- 19 68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Unknown</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.) <b>B &amp; O Railroad Tracks,</b>			21f. LOCATION Street or RFD No. City or Town County State <b>Emerson Street, Hyattsville, Prince George Co.,</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Kehoe MD</b>			EXAMINER'S NAME (Type) <b>John Kehoe MD</b>			22b. DATE SIGNED <b>7-22-68</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 25, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REG. STRAR <b>JUL 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



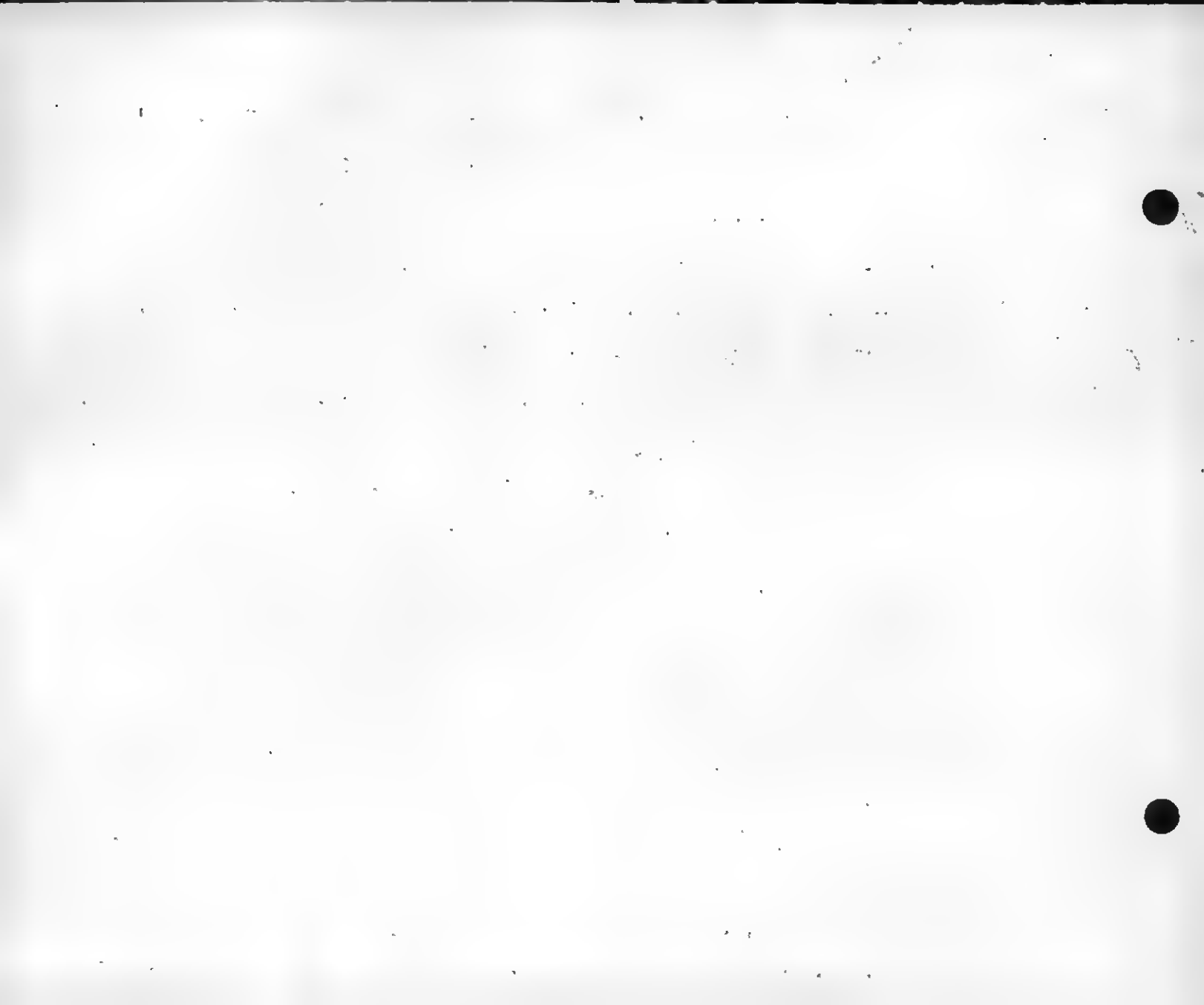


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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Bernard J. Fuller</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>1:50 am</b>			
3 SEX <b>male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>April 27, 1902</b>		6 AGE (In years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTH-PLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.			
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Eugene Leland Memorial Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution on residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Greenbelt</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6 Lake Crest Dr.</b>	
14 FATHER'S NAME First <b>Johann</b> Middle <b>J.</b> Last <b>Fuller</b>			15 MOTHER'S MAIDEN NAME First <b>Adelheit</b> Middle <b>Jansen-</b> Last <b>Jansen-</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>579-10-9001</b>		17 INFORMANT Address <b>E. Leland Mem. Hosp. 4408 Queensbury Rd.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Hemorrhage</b> <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>TOTAL GASTRECTOMY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARCINOMA OF STOMACH</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>?</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>151X Uremia &amp; wound infection</b>									
19a. DATE OF OPERATION <b>7-2-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TOTAL GASTRECTOMY</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-26</b> , 19 <b>68</b> , to <b>7-15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-15</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. F. Wilkinson</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7-16-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>R. F. Wilkinson</b>		22e. ADDRESS <b>1 immediate, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 19, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ga te of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wheaton Montgomery Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DW-3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

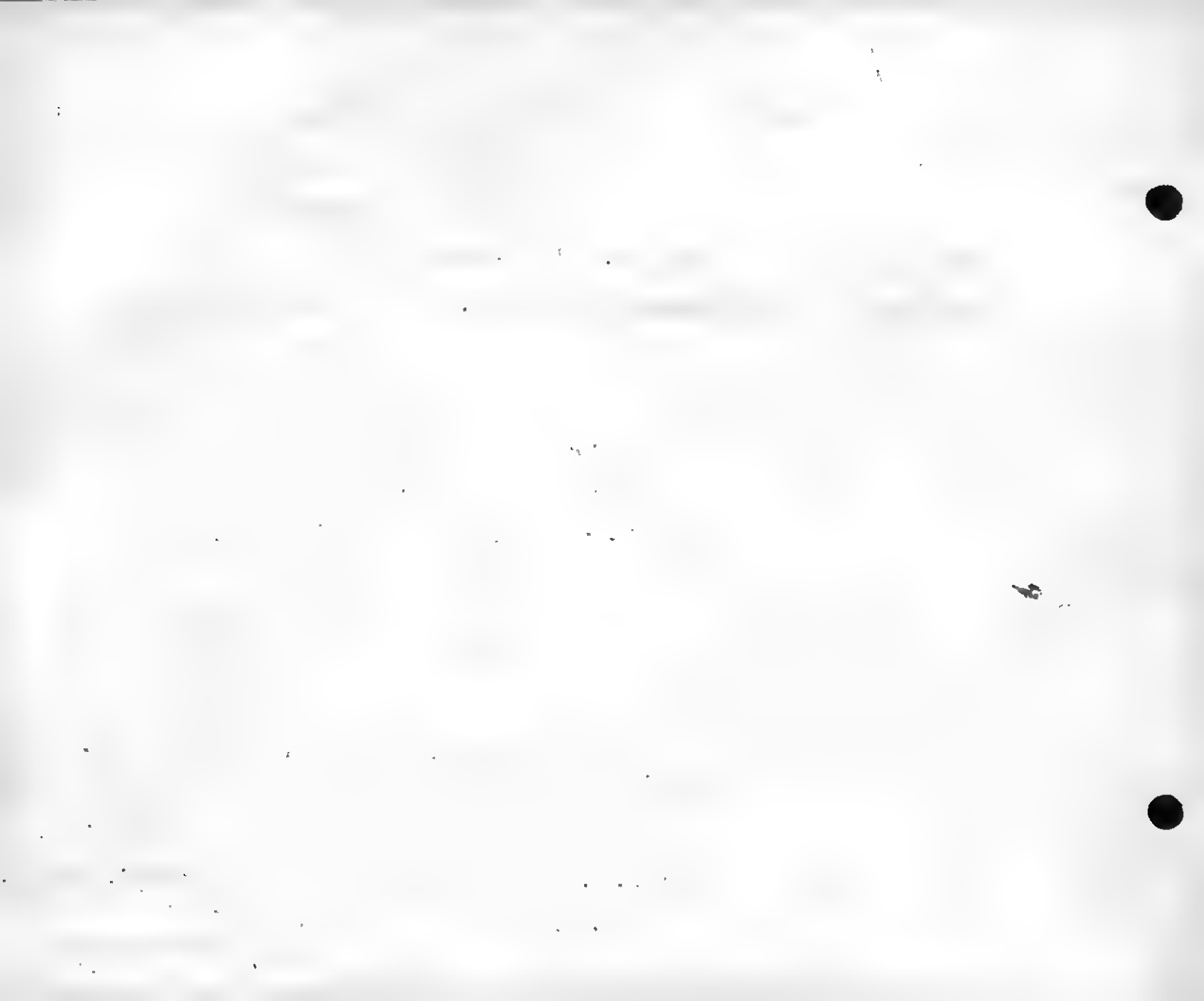
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)					First Middle Last		2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year		2b HOUR
Anita Dolores Galloway							OF ESTI- DEATH MATED <input type="checkbox"/> 7-26-68		192:30pm
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER YEAR	8 UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR	
Female	White	5-28-1968	YRS 1	MONTHS 28	DAYS 28	Month 7 Day 26 Year 68		192:30pm M.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md			
10 CITY OR TOWN OF DEATH Clinton			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Clinton Medical Center			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Infant		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Prince George's		13c CITY OR TOWN Clinton	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 7815 Surrats Road		
14 FATHER'S NAME First Middle Last Jake W. Galloway Sr.					15 MOTHER'S MAIDEN NAME First Middle Last Rose Briggs				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b SOCIAL SECURITY NO NONE		17 INFORMANT (Father) ADDRESS Jake W. Galloway Sr, Same as #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute peritonitis									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 576x									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 7-27-68	
ADDRESS (Street, city, town, or county)									
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE 7-30-68		23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d LOCATION (City or Town) (County) (State) PG County, Maryland			
24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. SE, Suitland, Maryland						25a REC'D BY REG STRAR DATE AUG 1 1968		25b REG STRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 5 & 7 Film 10/2/68									
1. DECEASED-NAME (Type or print) <b>Cyphers Garrison</b>					2a. DATE OF DEATH Month <b>July</b> , Day <b>29</b> , Year <b>1968</b>			2b. HOUR <b>1:30PM</b>	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>5/9/94 1905</b>		6. AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Cedar Hgts.</b>		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6230 Lee Place</b>	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. (If you give war or dates of service)		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Irreversible Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Gastric Dilatation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Post-op status from Intest. obst.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (this hospital) attended the deceased from <u>July 20</u> , 19 <u>68</u> , to <u>July 29</u> , 19 <u>68</u> , that (we) last saw the deceased alive on <u>July 29</u> , 19 <u>68</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>R. Longoria</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7-30-68</u>			
22d. PHYSICIAN'S NAME (Type) <b>Ricardo Longoria, M. D.</b>				22e. ADDRESS <b>Prince George's General Hospital, Cheverly.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>8-14-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Charmers</u>		23d. LOCATION (City or Town) (County) <u>Charmers</u> <u>Ham</u> <u>Maryland</u>			
24. FUNERAL DIRECTOR <u>Oscar Bames</u>				ADDRESS <u>#19-15th St SE</u>		25a. REC'D BY REGISTRAR <u>Oscar Bames</u>		25b. DATE <u>1968</u> <u>337</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Patrick Leo Gilmore</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>11:20</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2/18/1900</b>		6. AGE (In years last birthday) <b>68</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>W. Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.	
10. CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>retired - unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission to STATE) <b>Washington</b>		13b. COUNTY <b>Wash., D. C.</b>		13c. CITY OR TOWN <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>1536 17th St. N. W.</b>	
14. FATHER'S NAME First <b>Patrick</b> Middle <b>J.</b> Last <b>Gilmore</b>			15. MOTHER'S MAIDEN NAME First <b>Nora</b> Middle <b>A.</b> Last <b>Fallon</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>227-14-2546</b>		17. INFORMANT <b>Decedent</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY <b>492X</b> IMMEDIATE CAUSE (a) <b>Spontaneous pneumothorax, left</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>5277</b> (b) <b>massive bilateral pulmonary emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary tuberculosis, moderately advanced, active (5 yrs., 11 mos.); generalized arteriosclerosis.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that <b>he</b> (this hospital) attended the deceased from <b>7/12/</b> , 19 <b>67</b> , to <b>7/22/</b> 19 <b>68</b> , that <b>we</b> last saw the deceased alive on <b>7/22/</b> 19 <b>68</b> , and that <b>in our</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>he</b> (we) (did) <b>not</b> view the body after death.							
22b. SIGNATURE <b>Moe Weiss</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7/22/1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>				22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>7/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Covington, Virginia</b>	
24. FUNERAL DIRECTOR <b>The S.H. King Co. 2901 14th St. N.W. D.C.</b>				25a. REC'D BY REGISTRAR <b>JUL 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>John W. Glascoe</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1968</b>			2b. HOUR <b>5:30 A.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>October 11, 1890</b>		6. AGE (In years lost birthday) <b>77 1/2</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>	
10. CITY OR TOWN OF DEATH <b>Glenn Dale (rural)</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Unknown - retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Unknown John W. Glascoe Sr</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown Martha Booth</b>		13e. STREET AND NUMBER <b>2840 Bladensburg Road, N.E.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>579-07-6865</b>		17. INFORMANT Address <b>(Decedent)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary tuberculosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>  <b>1 yr. 1 mo.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>Generalized arteriosclerosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <b>6/14/</b> 19 <b>67</b> , to <b>7/2/</b> 19 <b>68</b> , that (X) (we) lost the deceased alive on <b>7/2/</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Moe Weiss</b>		22c. DATE SIGNED <b>July 2, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 5, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg Md.</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		ADDRESS <b>1661 Good Hope Rd S.E. WASH. D.C.</b>		25a. REC'D BY REG. STRAR <b>JUL - 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>Andrew</b>			First Middle Last <b>Glinos</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>7-30-68</b>			2b. HOUR <b>8:34pm</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>11-30-1941</b>	6. AGE (in years last birthday) <b>26</b> YRS	IF UNDER 18 MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <b>7 30 68</b>			2d. HOUR <b>8:34pm</b>			
7a. BIRTHPLACE (State or foreign country) <b>Greece</b>		7b. C.T.ZEN OF WHAT COUNTRY? <b>Greece</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>						
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial Hospital</b>			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Restaurant Owner</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>				
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before address on) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Riverdale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5309 Riverdale Rd., #625</b>				
14. FATHER'S NAME First Middle Last <b>Lois Glinos</b>				15. MOTHER'S M.A.DEN NAME First Middle Last <b>Unk</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No None</b>				16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS <b>Lois Glinos Father Washington, D.C.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Gun shot wound of chest</b> <b>765X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>6:37pm 7-30-1968</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <b>-</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>			21f. LOCATION Street or R.F.D. No City or Town County State <b>Same as # 13</b>						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>John Kehoe MD</b>			EXAMINER'S NAME (Type) <b>John Kehoe MD</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>7-31-68</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>8/5/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>			23d. LOCATION (City or town) (County) (State) <b>Colmar Manor, Md.</b>				
24. FUNERAL DIRECTOR <b>Valley's Funeral Home Mt. Rainier, Md.</b>						25a. REC'D BY REGISTRAR <b>AUG 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR			
Betty			A.		Goetz	July 6 68		9:45 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years lost birthday)		7. UNDER 1 YEAR			
Female		Caucasian		21 Oct 27		48 YRS		MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Wash., D.C.		USA				Prince George's County Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Andrews AFB			Malcomb Grow USAF Hosp.			Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Prince George		Oxon Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7309 Oxon Hill Rd.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Carol					Amiss	Mabyl					Hanback
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No						Col. Robert T. Goetz			7309 Oxon Hill Rd. Md.		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anoxia</u>									24 hr.		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent Bronchogenic Ca.</u>									1 yr.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
			Ca of lung			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION		City or Town		State	
						Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>6 July</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>5 July</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED			
Frank A. Camp						DEGREE		6 July 68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Frank A. Camp M.D.						Malcolm Grow USAF Hospital Andrews AFB, Wash., D.C. 20331					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial			7/8/68		Cedar Hill		Suitland, Md				
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lee Funeral Home						Washington, D.C.		JUL 10 1968		Charles Judge	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR	
Alex Robert Grieshamer						7-21-68		19	10:00	pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS M.N.	2c. DATE PROMOUNCED DEAD		Month	Day	Year
Male	White	7-21-1891	77					7-22-68		19	05am	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY			
Illinois		U S A.				Prince George's			U S Government			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George Hospital			Mechanic			U S Government			
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		3d. INSIDE CITY L.M.T.S?		13e. STREET AND NUMBER		
Maryland			Prince George's			Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3006 Bendix Lane		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Charles R Grieshamer						Margaret Dixon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
no			579 52 1331			Edward Grieshamer			Bowie, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY?				
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
				10:00pm 7-21-19 68				Shot self with .32 cal. automatic pistol				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21f. LOCATION (Street or R.F.D. No. City or Town County State)				
				Home				Same as # 13				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED				
EXAMINER'S NAME (Type) John Kehoe MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				7-23-68				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR REMOVAL		23d. LOCATION (City or Town) (County) (State)				
Burial				July 24, 1968		George Washington		Hyattsville Pro Geo Md.				
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons				Hyattsville, Md.				JUL 26 1968		Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Ernest			William			Griggs			July 21 1968 2,55AM
3 SEX	4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
Male	White		9 Oct., 1915			52 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Washington D C		U S A.				Pr. Geo., Md			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Pr. Geo. Gen Hosp.,			Retired roofer		self	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY L.M. 159 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Pr. Geo.,		Hillside			1307 57th Avenue...	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
John A Griggs			Mamie O Harbin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
			577 09 6359		Ernest W Griggs Jr Washington D. C.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac arrest due to atherosclerosis</u>								1h	
4127 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic heart disease</u>								1i	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary heart disease</u>								1j day	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from July 18, 1968, to July 21, 1968, that (I) (we) last saw the deceased alive on July 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED		
T Bergman			MD				July 21/68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
			Greenbelt, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/23/68		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F Gasch's Sons Hyattsville, Md.				DATE JUL 25 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 44-101  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Irene E Hanglitter						July 1 1968			2,45AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		15 Nov., 1895		72 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
New Jersey		U.S.A.				Prinee Georges Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Pr. Geo. Gen. Hosp.,			Ret. U.S. Govt.			
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Pr., Geo.		Hyattsville				2502 Queens Chapel Rd.
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Edward R. Hanglitter						Elina J. Krow			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT				Address
no			217-52-8044-T		Dorothy V. Hanglitter				(above ad-)
18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, pontine</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3322</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Divertericulosis - hemorrhagic; arteriosclerotic heart disease - myocardial infarction</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
6/15/68		Divertericulosis - hemorrhagic			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 6/15, 1968, to 7/1, 1968, that (I) (we) last saw the deceased alive on 6/13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b SIGNATURE					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE/SIGNED		
Jerome Sandler, M. D.							7/1/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Jerome Sandler, M. D.					1726 Eye St., NW, Washington, D.C.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		7/3/68		Wash. Natl. Cem.		Suitland Pr. Geo. Md.			
24. FUNERAL DIRECTOR (Name and address)					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
James L. Rainier, Inc.					JUL 10 1968		Charles Judge		



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div style="display: flex; justify-content: space-between;"> <span>10461</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>10470</span> </div> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>															
1. DECEASED NAME (Type or print)				First Middle Last				2a. DATE OF DEATH Month Day Year				2b. HOUR 9:05 PM			
3. SEX F				4. RACE WHITE				5. DATE OF BIRTH 8-9-94				6. AGE (In years last birthday) 73 YRS.			
7a. BIRTHPLACE (State or foreign country) Pa.				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince George's Md.			
10. CITY OR TOWN OF DEATH Lanham				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife				12b. KIND OF BUSINESS OR INDUSTRY —			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md.				13b. COUNTY PG.				13c. CITY OR TOWN BRENTWOOD				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S MAIDEN NAME First Middle Last Unknown				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No				16b. SOCIAL SECURITY NO. —			
17. INFORMANT S. J. Kest Address Arlington, Va.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA BILATERAL</u> 4279 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332 <u>Diabetes Mellitus</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 7 days 2 yrs			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State				21g. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				21h. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
22a. I certify that (I) (this hospital) attended the deceased from 8/31, 1953, to 7/2, 1968, that (I) (we) last saw the deceased alive on 7/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE Norman Donat Concan		22c. DATE SIGNED 7/2/68	
22d. PHYSICIAN'S NAME (Type) Norman Donat Concan				22e. ADDRESS 3503 Perry St Mt Rainier Md.				22f. ADDRESS 3503 Perry St Mt Rainier Md.				22g. ADDRESS 3503 Perry St Mt Rainier Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 7-5-68				23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				23d. LOCATION (City or Town) (County) (State) Arlington Pa.			
24. FUNERAL DIRECTOR Valley Funeral Home				25a. REC'D BY REGISTRAR JUL 10 1968				25b. REGISTRAR'S SIGNATURE Charles Judge				25c. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Florence E. Hardesty</b>			2a. DATE OF DEATH <b>July</b> Month <b>9</b> , Day <b>1968</b> Year			2b. HOUR <b>9:05AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>March 19, 1888</b>		6. AGE (In years last birthday) <b>80</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Cheverly</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2802 63rd Place</b>	
14. FATHER'S NAME First Middle Last <b>Benjamin Dare</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Alice Smith</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT (son) Hyattsville, Address Maryland <b>Bernard H Hardesty Jr. 4709 68 Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Tamponade.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Ruptured myocardial infarct.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary arteriosclerotic heart disease.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) <del>did not</del> attended the deceased from <b>1947</b> to <b>July 9, 1968</b> , that (I) <del>was</del> last saw the deceased alive on <b>July 9, 1968</b> , and that in (my) <del>(sex)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(xxx)</del> (did) <del>(do not)</del> view the body after death.									
22b. SIGNATURE <i>Julius Kauffman, MD</i>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7/9/68</b>			
23a. PHYSICIAN'S NAME (Type) <b>Julius Kauffman, M. D.</b>		22e. ADDRESS <b>6501 Landover Rd., Cheverly, Md. 20785</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Rd. SE, Suitland, Maryland</b>				25a. REC'D BY REGISTRAR <b>JUL 15 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) <b>CLARA B. HART</b>			2a DATE OF DEATH 7 Month 5 Day 68 Year			2b. HOUR M			
3 SEX <b>FEMALE</b>		4. RACE <b>Negro</b>		5 DATE OF BIRTH <b>9/8/98</b>		6 AGE (In years last birthday) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>AMISSVILLE, VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George</b> Md			
10 CITY OR TOWN OF DEATH <b>Hyattsville, Md.</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL MANOR 4922 LA SALLE Rd.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>D. C.</b>		13b COUNTY		13c CITY OR TOWN <b>WASH. D.C.</b>		13d INSIDE CITY (Y.N.T.S?) YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>308 EMERSON ST. N.W.</b>	
14 FATHER'S NAME First Middle Last <b>WALTER SMITH</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>LAURA DAVENPORT</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>579-16-69448B</b>			17. INFORMANT <b>SP. M. CATHERINE Bernadette</b>			Address <b>CARROLL MANOR 4922 LA SALLE Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac and respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cancer of the stomach</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No		City or Town		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>7/5</b> , 19 <b>68</b> , to <b>7/5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph A. Romeo MD</b> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <b>7/5/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Joseph A. Romeo M.D.</b>				22e ADDRESS <b>4731 Mass. Ave. Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>7-9-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince George, Md.</b>			
24 FUNERAL DIRECTOR <b>JOHN T. Rhines Co.</b>		25a REC'D BY REGISTRAR <b>3015 124 St.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		JUL 10 1968			



# FOR STATE HEALTH DEPT.

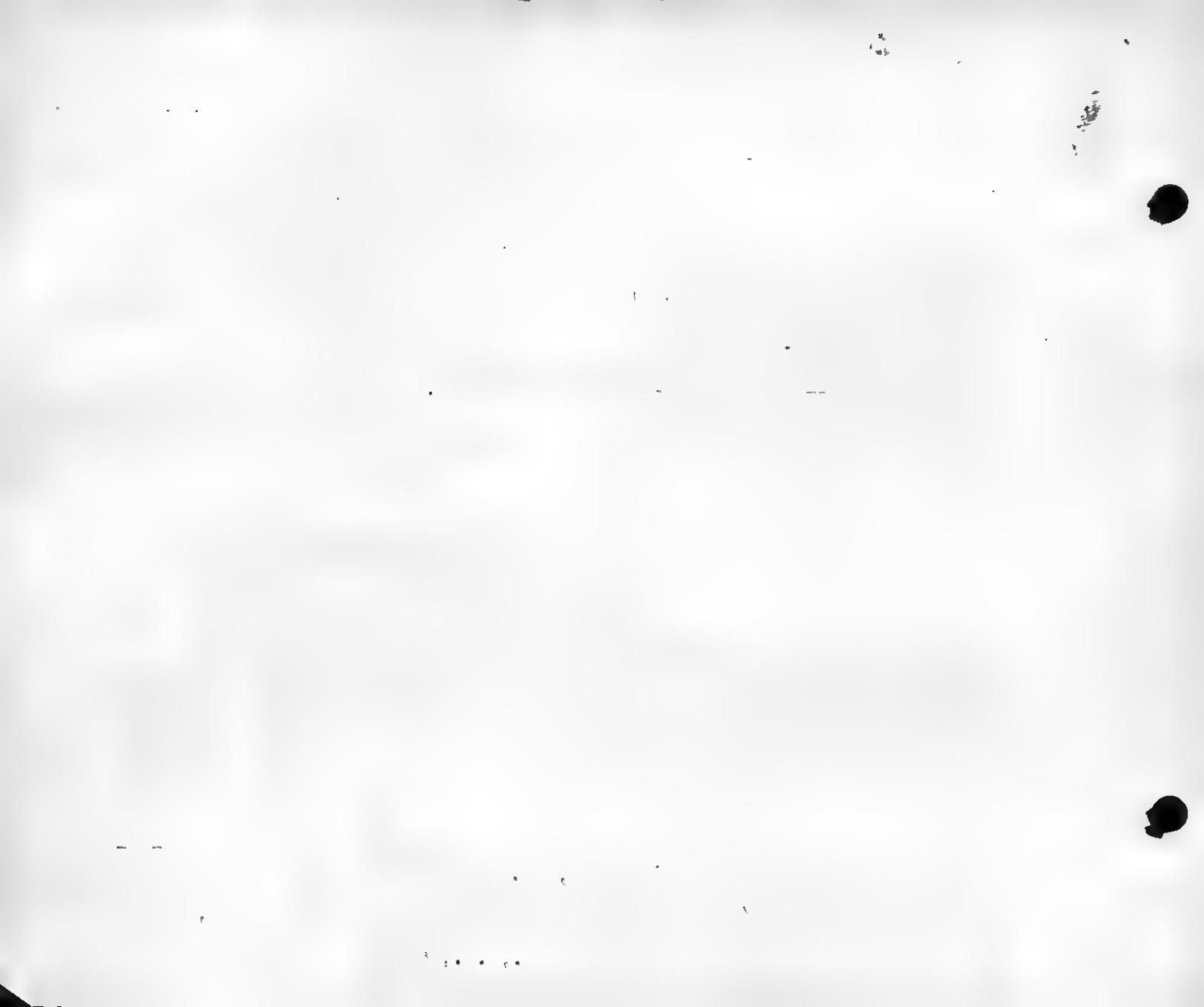
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-22a Film 405 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 7-17-68 19 2:00pm			2b HOUR		
Clara K Hartley											
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Female	White	11-17-1917	50 YRS					7 17 68			5:45pm M
7b BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
VIRGINIA		USA				Prince George's Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Riverdale			Leland Memorial Hospital			CLERK-TYPIST			UNION		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Prince George's		Hyattsville				4205 Van Buren Street		
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last							
EMMETT L. KITCHEN				CORA LEE BRANCH							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO (If yes give year or dates of service)		17 INFORMANT			ADDRESS			
NO			578-10-4177		JASPER P. HARTLEY			SAME AS # 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Barbiturate intoxication</u> 1500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year 1:00 PM 7-17 19 68			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Ingested overdose of barbiturates					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) Home			21f LOCATION Street or RFD No City or Town County State Hyattsville Pr. Geo. Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			22b DATE SIGNED					
<i>John Kehoe</i>			John Kehoe MD			7-18-68					
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
BURIAL			7/20/68		NATIONAL MEMORIAL PARK			FALLS CHURCH, VIRGINIA			
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
<i>Joseph Samuels Son Inc.</i>						5130 Wisconsin Ave., N.W.		JUL 23 1968		<i>Charles J. J...</i>	



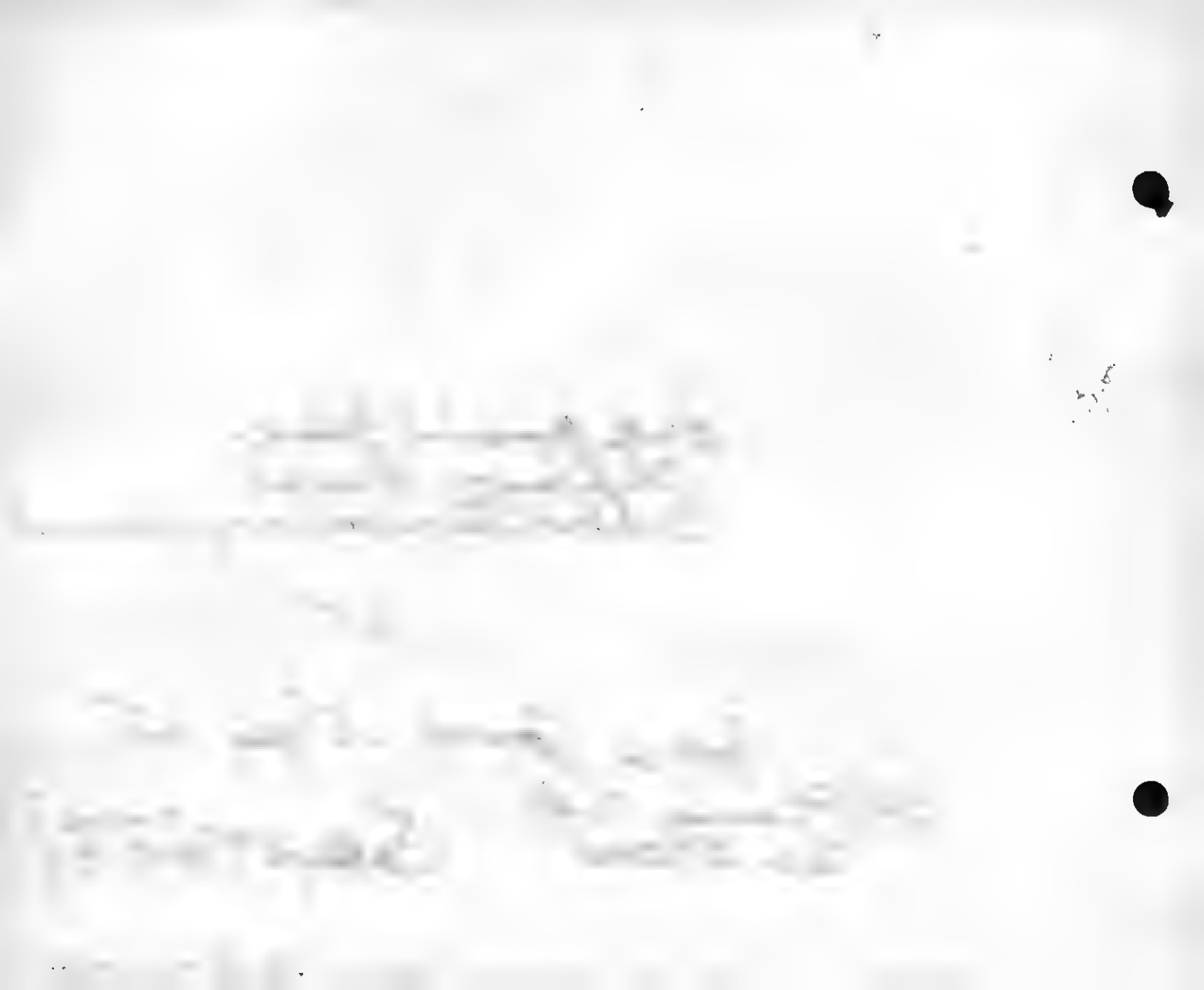
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please detach pages 1 and 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Samuel H. Harvey			2a. DATE OF DEATH Month 7 Day 27 Year 68		2b. HOUR 1:57 PM	
3 SEX Male	4 RACE White	5. DATE OF BIRTH July 7, 1894		6 AGE (In years last birthday) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) CONN.	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) President		12b. KIND OF BUSINESS OR INDUSTRY Dairy	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Md.	13b. COUNTY Prince George	13c. CITY OR TOWN College Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7304 Princeton ave.		
14. FATHER'S NAME First Middle Last Samuel B. Harvey			15. MOTHER'S MAIDEN NAME First Middle Last Evelyn Bennett			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 214-01-0241		17. INFORMANT Marcel J. Harvey, College Park Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's Disease DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Arteriosclerosis advanced Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause past					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATED ON Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from March 1968, to July 1968, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (d/d) (did not) view the body after death						
22b. SIGNATURE W.L. Etienne		22c. DATE SIGNED 7-27-68		22d. PHYSICIAN'S NAME (Type) W.L. ETIENNE		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 31, 1968		23c. NAME OF CEMETERY OR CREMATORY Storrs Cemetery		
24. FUNERAL DIRECTOR F. Gasch's Sons		23d. LOCATION (City or Town) (County) (State) Storrs Connecticut		25a. REC'D BY REGISTRAR AUG 1 1968		
25b. REGISTRAR'S SIGNATURE Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 115-1  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>GRACE BROCK HASTE</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR <b>8:00A</b>			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>March 22, 1907</b>		6 AGE (n years lost birthday) <b>61</b> YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>N Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md			
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Eugene Ieland Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6103 40th Avenue</b>	
14 FATHER'S NAME First <b>James</b> Middle <b>Brock</b> Last <b>Small</b>		15. MOTHER'S MAIDEN NAME First <b>Maddy</b> Middle <b>L</b> Last <b>Small</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO <b>578-42-0799</b>		17. INFORMANT <b>Joseph B. Haste</b>		Address <b>Lanham, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>444.2</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>MESENTERIC THROMBOSIS</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE DAY</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PARKINSON'S DISEASE</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>21 JULY, 1968</b> , to <b>27 JULY, 1968</b> , that (I) (we) last saw the deceased alive on <b>26 JULY, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>C J Houmann</b>		DEGREE <b>C J Houmann</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>27 JULY 68</b>			
22d. PHYSICIAN'S NAME (Type) <b>C J Houmann</b>		22e. ADDRESS <b>Eland Hospital Riverdale, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 29, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar "A" Manor Pro Geo Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR			
James		H.		Hedgeman	July 4 1968		12:30 AM			
3 SEX	4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male	Negro		10/14/1899		68 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH				
Virginia		U. S. A.				Prince Georges Md				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Glenn Dale		Glenn Dale Hospital		unknown - retired		unknown				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm ssion) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
		13b COUNTY		Wash., D.C.				636 Farragut St., N. W.		
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last	
James		--		Hedgeman	Nannie Cole					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT					Address	
yes		1918		579-05-1986					Decedent	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cor pulmonale</u>								1 mo.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								10 yr.		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary tuberculosis</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary emphysema</u>								10 yr.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)										
21f. LOCATION Street or RFD No City or Town County State										
22a. I certify that (this hospital) attended the deceased from <u>9/6/</u> , 19 <u>67</u> , to <u>7/4/</u> , 19 <u>68</u> , that <del>he</del> (we) last saw the deceased alive on <u>7/4/</u> , 19 <u>68</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.										
22b. SIGNATURE <u>Moe Weiss</u>										
22c. DATE SIGNED <u>7/4/1968</u>										
22d. PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>										
22e. ADDRESS <u>Glenn Dale Hospital</u> <u>Glenn Dale, Maryland</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		9 JULY 1968		LINCOLN MEM.		SUITLAND MARYLAND				
24. FUNERAL DIRECTOR <u>ROBERT G. MCQUIRE</u> ADDRESS <u>820 9th St</u>										
25a. REC'D BY REGISTRAR <u>Charles Judge</u>										
25b. REGISTRAR'S SIGNATURE										



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA-1005. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print)			First <b>Elizabeth</b>			Middle <b>Mary</b>			Last <b>Henry</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-26-68 1911:00am			2b. HOUR		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>12-3-1895</b>		6. AGE (In years last birthday) <b>72</b> YRS		F UNDER 1 YEAR MONTHS _____ DAYS _____		F UNDER 24 HRS HOURS _____ MIN _____		2c. DATE PRONOUNCED DEAD Month <b>7</b> Day <b>26</b> Year <b>1968</b>			2d. HOUR <b>11:08am</b>		
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Prince George's</b> Md					
10. CITY OR TOWN OF DEATH <b>Riverdale</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Heland Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) - STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Hyattsville</b>				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4009 Gallatin Street, #405</b>							
14. FATHER'S NAME First <b>Joseph</b> Middle <b>Robson</b> Last <b>Robson</b>						15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Morgans</b> Last <b>Morgans</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. (If yes give year or dates of service) <b>None</b>		17. INFORMANT <b>Lloyd E Henry</b>		ADDRESS <b>4009 Gallatin St.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>7</b> DUE TO, OR AS A CONSEQUENCE OF <b>Hypertensive cardio vascular disease over 1 yr.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>443x Diabetes mellitus - over 20 yrs.</b>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or RFD No _____ City or Town _____ County _____ State _____									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>John Kehoe MD</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>7-26-68</b>									
EXAMINER'S NAME (Type) <b>John Kehoe MD</b>				ADDRESS <b>Riverdale, Md.</b>				ADDRESS (Street, city, town, or county)									
23a. BURIAL CREMATION REMOVAL (Specify) <b>burial</b>				23b. DATE <b>7/29/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Maryland</b>							
24. FUNERAL DIRECTOR <b>Valley Funeral Home Mt. Rainier, Md.</b>						ADDRESS		25a. RECD BY REGISTRAR DATE <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										78	
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>Blanche B Herbert</b>			2a. DATE OF DEATH Month Day Year <b>7-30-68</b>			2b. HOUR <b>7:05 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12-12-1970</b>		6. AGE (In years lost birthday) <b>97</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.					
10. CITY OR TOWN OF DEATH <b>Clinton</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View Gardens</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>St. Charles</b>		13c. CITY OR TOWN <b>Indian Head</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>29 Potomac Ave.</b>		
14. FATHER'S NAME First Middle Last <b>John Lambert Beadd</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Eliza Carpenter</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO <b>219-48-4806</b>		17. INFORMANT <b>Miss Laura B. Yates-Niece</b> <b>29 Potomac Ave, Indian Head, Md</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INTESTINAL OBSTRUCTION CHRONIC</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>LARGE BOWEL, DIVERTICULITIS-DIVERTICULOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>3020</b> <b>10 MIN.</b> <b>3 WKS.</b> <b>3 MOS.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PROBABLE CECAL CARCINOMATOSIS</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (If either, not by medical examination) <b>None</b>		21b. TIME OF INJURY HOUR A.M. <b>None</b> P.M. <b>None</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>None</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <b>None</b>		21e. PLACE OF INJURY (AT HOME - FARM STREET, FACTORY) OFFICE BUILDING, ETC. <b>None</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>None</b>						
22a. I certify that (this hospital) attended the deceased from <b>7-10-68</b> , to <b>7-30-68</b> , that (I) last saw the deceased alive on <b>7-30-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (do) view the body after death.											
22b. SIGNATURE <b>Arthur Shaver MD</b>										22c. DATE SIGNED <b>7/30/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER STRMD 8808 BRANCH AVE CLINTON</b>										22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL <b>Interment</b>		23b. DATE <b>8/2/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>La Plata, Md.</b>				
24. FUNERAL DIRECTOR <b>Archart Funeral Home, Inc.</b>				ADDRESS <b>La Plata, Md</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Maryland State Department of Health  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 17 Film 6403 2/18/65  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) First Middle Last <b>LEWIS K HILE</b>			2a. DATE OF DEATH Month Day Year <b>JULY 27 1965</b>		2b. HOUR <b>1138 P.M.</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>Sept 18, 1900</b>	6. AGE (in years lost birthday) <b>67</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Kansas</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md.		
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>PRINCE</b>	12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>VEHICLE INSURER</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD</b>	13b. COUNTY <b>PG</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3a. STREET AND NUMBER <b>12412 Skitter Lane</b>	
14. FATHER'S NAME First Middle Last <b>DE WITT HILE</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Gertie B Zuck</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>577-10-5857</b>	17. INFORMANT <b>7713 Tipton St. New Carrollton, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> <b>4127</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>VENTRICULAR FIBRILLATION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b> <b>30 MIN</b> <b>6 YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 19 <b>66</b> to <b>JULY</b> , 19 <b>65</b> , that (I) (we) lost the deceased on <b>JUNE 24</b> , 19 <b>65</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Norman K Bohrer</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>July 28, 1965</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr Norman Bohrer</b>		22e. ADDRESS <b>3231 Superior Ave Bowie Md 20745</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 31, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 1 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) First Middle Last <b>Flossie Irene Hill</b>						2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-12-68 197:00am M			2b. HOUR		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>3-20-1895</b>		6 AGE (in years last birthday) <b>73</b> YRS		F UNDER YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <b>7 12 68</b> 19 10:25am	
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md			
10 CITY OR TOWN OF DEATH <b>Riverdale</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life even retired) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>				13b COUNTY <b>Frederick Brunswick</b>		13c CITY OR TOWN <b>Brunswick</b>		3d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>538 Brunswick St.</b>	
14 FATHER'S NAME First Middle Last <b>Charles David Albert</b>						15 MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Riley</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>no</b>				16b SOCIAL SECURITY NO		17 INFORMANT <b>Harry Le Roy Hill</b>				ADDRESS <b>Brunswick, Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>over 15 yrs.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>420c</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State						
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe MD</b>		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
						ADDRESS (Street, city, town, or county)		22b DATE SIGNED <b>7-12-68</b>			
23a BURIAL CREMATION <b>CREMATION</b>		23b DATE <b>7/15/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Park Heights Cemetery</b>				23d LOCATION (City or Town) (County) (State) <b>Brunswick, Fred. Md.</b>			
24 FUNERAL DIRECTOR <b>Feste Funeral Home</b>				ADDRESS <b>Brunswick, Md.</b>				25a REC'D BY REG STRAR DATE <b>JUL 16 1968</b>		25b REG STRAR'S SIGNATURE <b>J. Charles Judge</b>	

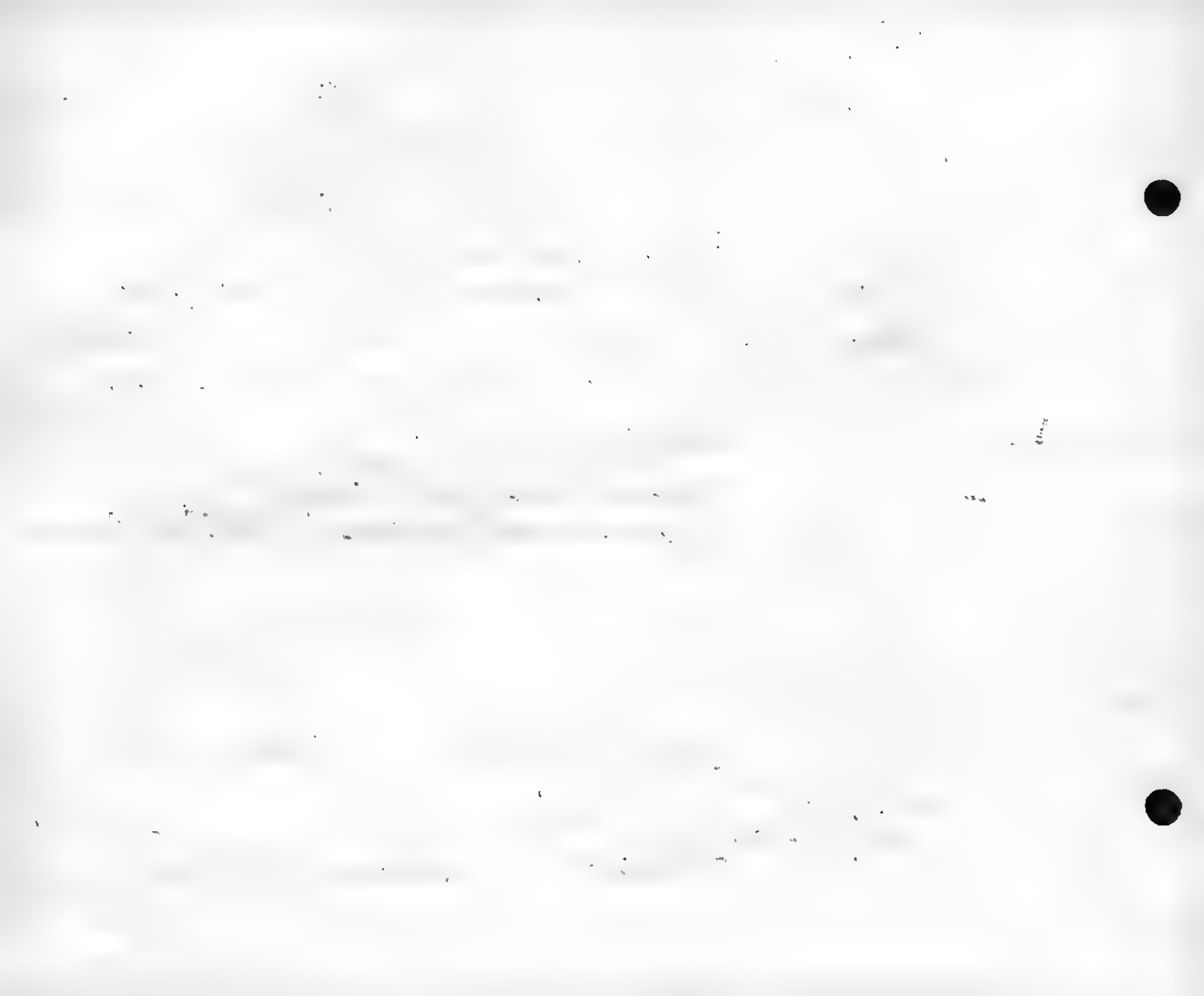


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) <i>Mable</i>			2a DATE OF DEATH Month <i>July</i> Day <i>24</i> Year <i>68</i>			2b HOUR <i>4 PM</i>					
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH <i>6/2/1892</i>		6 AGE (In years last birthday) <i>86</i> YRS		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>N.Y.</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Prince Georges</i> Md					
10 CITY OR TOWN OF DEATH <i>Greenbelt</i>			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Greenbelt Convalescent Center</i>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i>			13b COUNTY <i>P.G.</i>		13c CITY OR TOWN <i>LANHAM</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>9302 Wellington St.</i>		
14 FATHER'S NAME First <i>Harney</i> Middle <i>W.</i> Last <i>Boonn</i>			15 MOTHER'S MAIDEN NAME First <i>Alice</i> Middle <i>E.</i> Last <i>Casper</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO <i>055 16 9096</i>			17 INFORMANT <i>Mrs ALAN C Hill</i>			Address <i>Same</i>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertensive/arteriosclerotic Cerebral Vascular Change</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from <i>July 23</i> , 19 <i>68</i> , to <i>July 24</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>July 23</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <i>W. L. Etienne</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <i>7-24-68</i>		
22d PHYSICIAN'S NAME (Type) <i>W. L. ETIENNE</i>						22e ADDRESS <i>College Park, Md.</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>July 28, 1968</i>			23c NAME OF CEMETERY OR CREMATORY <i>Bramanville Cemetery</i>			23d LOCATION (City or Town) (County) (State) <i>Cobleskill, New York</i>		
24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>			ADDRESS <i>Hyattsville, Md.</i>			25a REC'D BY REGISTRAR <i>JUL 29 1968</i>			25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-1-64  
30M REV 1-68

**CERTIFICATE OF DEATH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 DECEASED-NAME (Type or print) <b>JAMES</b>			First Middle Last			2a. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>68</b>			2b HOUR <b>0010 M</b>		
3 SEX <b>Male</b>			4 RACE <b>Caucasion</b>			5. DATE OF BIRTH <b>16 Dec 1888</b>			6 AGE (In years lost birthday) <b>79</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Hungary</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's County Md.</b>		
10. CITY OR TOWN OF DEATH <b>Andrews AFB</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Malcolm Grow USAF Hosp</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Military</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Caroline</b>			13c. CITY OR TOWN <b>Greensboro</b>			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
13e. STREET AND NUMBER <b>Box 243</b>			14 FATHER'S NAME First Middle Last <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>1706-1932</b>			17. INFORMANT <b>6 YR</b>			Address <b>Son-10 16th St. Englewood Cliffs, NJ</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>1. Not known. embolus</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cancer of Rectum</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>?</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1. 1st</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Frank A. Camp</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10 July 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>FRANK A CAMP MAJ USAF MC</b>						22e. ADDRESS <b>MALCOLM GROW USAF HOSP, ANDREWS AFB, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7-13-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>			23d. LOCATION (City or Town) (County) (State) <b>Greensboro Md.</b>		
24. FUNERAL DIRECTOR <b>J. E. Boulaie</b>						ADDRESS <b>Greensboro, Md.</b>			25a. REC'D BY REGISTRAR <b>JUL 15 1968</b>		
									25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Emmons</b>			First Middle Last <b>-- Holman</b>			2a. DATE OF DEATH Month Day Year <b>July 3 1968</b>			2b. HOUR <b>10:00 PM</b>		
3 SEX <b>Male</b>			4 RACE <b>Negro</b>			5. DATE OF BIRTH <b>1/5/1905</b>			6. AGE (In years last birthday) <b>63</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>N. C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince Georges</b> Md.		
10. CITY OR TOWN OF DEATH <b>Glenn Dale</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>unemployed- unknown</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>STATE</b>			13b. COUNTY <b>Wash., D. C.</b>			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>No fixed address</b>		
14. FATHER'S NAME First Middle Last <b>Unknown</b>			15. MOTHER'S M A DEN NAME First Middle Last <b>Maggie -- Holman</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>yes 1939-1945</b>			16b. SOCIAL SECURITY NO <b>579-05-1537</b>		
17. INFORMANT Address <b>Decedent</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RECURRENT CEREBROVASCULAR ACCIDENT</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> (c) <b>YEARS</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>PULMONARY TUBERCULOSIS, CORONARY ARTERY DISEASE</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>2/9/1968</b> , to <b>7/3/1968</b> , that <del>we</del> (we) last saw the deceased alive on <b>7/3/1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) (d) (d) <del>did not</del> view the body after death.											
22b. SIGNATURE <b>Moe Weiss</b>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <b>7/3/1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>						22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>JULY 9, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>LANDOVER Md</b>		
24. FUNERAL DIRECTOR <b>William Spangler</b>			ADDRESS <b>Spangler Funeral Home Wash. D.C.</b>			25a. REC'D BY REGISTRAR <b>JUL 10 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year		2b HOUR	
Beatrice Jackson						7-28-68		19 1:00am	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (n years last birthday)	7 UNDER 1 YEAR MONTHS DAYS HOURS MIN	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
Female	Negro	5-17-1948	19			7 28 68		19 1:26am	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		9 COUNTY OF DEATH					
W.D.C.		USA		Prince George's			Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Cheverly		Prince George Hospital			Student				
13a U.S.A. RESIDENCE (Where deceased lived if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
District of Columbia		Washington				YES		322 54th. Street, N.E.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
CHARLES W JACKSON			BEATRICE WHITE						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
NO		UNKNOWN		BEATRICE WHITE		322 54th ST NE W.D.C.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Evisceration</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Laceration of abdominal wall</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>									
(c) <u></u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>1124</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			1:00am 7-28- 19 68		Pedestrian struck by car.				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory office building, etc)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
		Rt. 50 at Cheverly exit, Prince George County, Maryland							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)			John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		7-29-68	
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
		8/3/68		HARMONY		Landover A.G. MD			
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG. STRAR DATE		25b REGISTRAR'S SIGNATURE	
W.W. Chambers			1400 CHAPIN ST.			AUG 6 1968		Charles Judge	

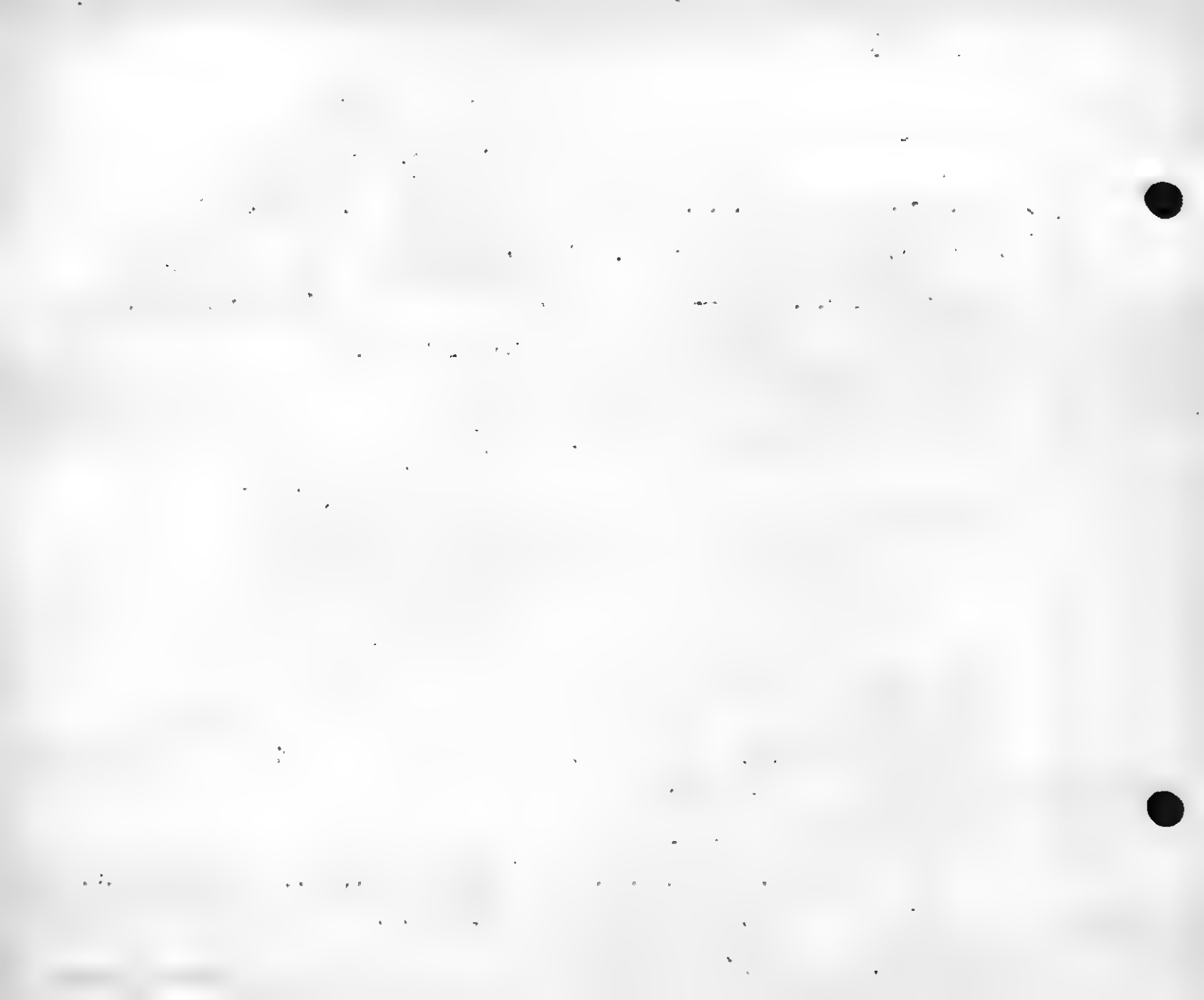


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remake carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR						
Baby			Boy			Johnson			July Month 29, Day 1968			4:05 P.M.			
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (In years lost birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male			Negro			July 29, 1968			YRS.			MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY			
Maryland			U.S.A.			Prince George's			Md						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY						
Cheverly			Prince Geo. Gen'l Hospital												
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Washington, D.C.			----			Washington			YES <input type="checkbox"/> NO <input type="checkbox"/>			1228 Savannah St.			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME												
First Middle Last			First Middle Last												
Willie			Johnson			Mary Ellen Barlow									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 7701 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia secondary to placenta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
		HOUR A.M. Month Day Year P.M. 19													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State					
22a. I certify that (I) (the hospital) attended the deceased from 7/29, 1968, to 7/29, 1968, that (I) (we) saw the deceased alive on 7/29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
Harry E. Altman, M.D.										7/29/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS									
						2025 Eye St., NW., Washington, D.C. 20006									
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
		8/17/68		Prince Geo. General Hosp		Cheverly, Md.									
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
HARRY W. PENN, JR., ADMINISTRATOR						DATE AUG 20 1968		J. Charles Judge							



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the director, page 3 should be detached for use as the burial-transit permit. This permit should be filed with the State Dept. of Health prior to burial, cremation, or other disposition of the body.

should be filed with the State Dept. of Health prior to burial, cremation

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		Month		Day		Year		2b HOUR	
Augusta				D		Johnson		July		24		68		11 45 P M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Female		White		8-9-69		75 8 1/2 YRS		MONTHS		DAYS		HOURS		MIN.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH											
Maryland		United States		Prince Georges													
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY											
Hyattsville, Md		Hyattsville Nursing Home		Housewife		Own home											
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER									
Maryland		Prince Georges		Hyattsville		YES		3410 Dodge Park Rd									
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle		Last			
Marian		Duckett						Gabriella A Du Val									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address											
No		57730 8615		House King		9901 Edgehill Lane		Silver Spring, Md									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction																	
4104 DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
(b) Arteriosclerotic coronary disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
Parkinson's disease, Glaucoma, left blind																	
19a. DATE OF OPERATION		19b. COND.TION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC				21f. LOCAT ON		Street or R.F.D. No		City or Town		County		State			
22a I certify that (1) (this hospital) attended the deceased from July, 1967, to July, 1968, that (1) (we) last saw the deceased alive on 28 July 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf																	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) First Middle Last Lawrence Marvin Jones						2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- 7 9 1968 DEATH MATED <input type="checkbox"/>			2b. HOUR ab 11 a M		
3 SEX male	4 RACE white	5 DATE OF BIRTH 10-27-11	6 A 57 YRS	7 F UNDER YEAR MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year 7 9 1968			2d. HOUR 11:50 a M			
7a. BIRTHPLACE (State or foreign country) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Plumber			12b. KIND OF BUSINESS OR INDUSTRY Plumbing			
13a. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Chillum		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1507 Ray Road, Apt. 102			
14. FATHER'S NAME First Middle Last Unknown				15. MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 577-05-2634		17. INFORMANT Stuart Carneal,		ADDRESS 1515 Ray Road Chillum, Md. Apt 102 20782			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute toxicology -- Librium & alcohol DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8880											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		2. b. TIME OF INJURY Month, Day, Year A 9:00 AM 9: AM P M 7-9 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Took excess amount of Librium while drinking alcohol							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No Chillum Pr. Geo.		City or Town Md.		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-11-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City or Town) Bladensburg, Maryland		County		State	
24. FUNERAL DIRECTOR W. W. CHAMBERS CO. Riverdale, Md.				25a. REC'D BY REG. STRAR DATE JUL 15 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge					

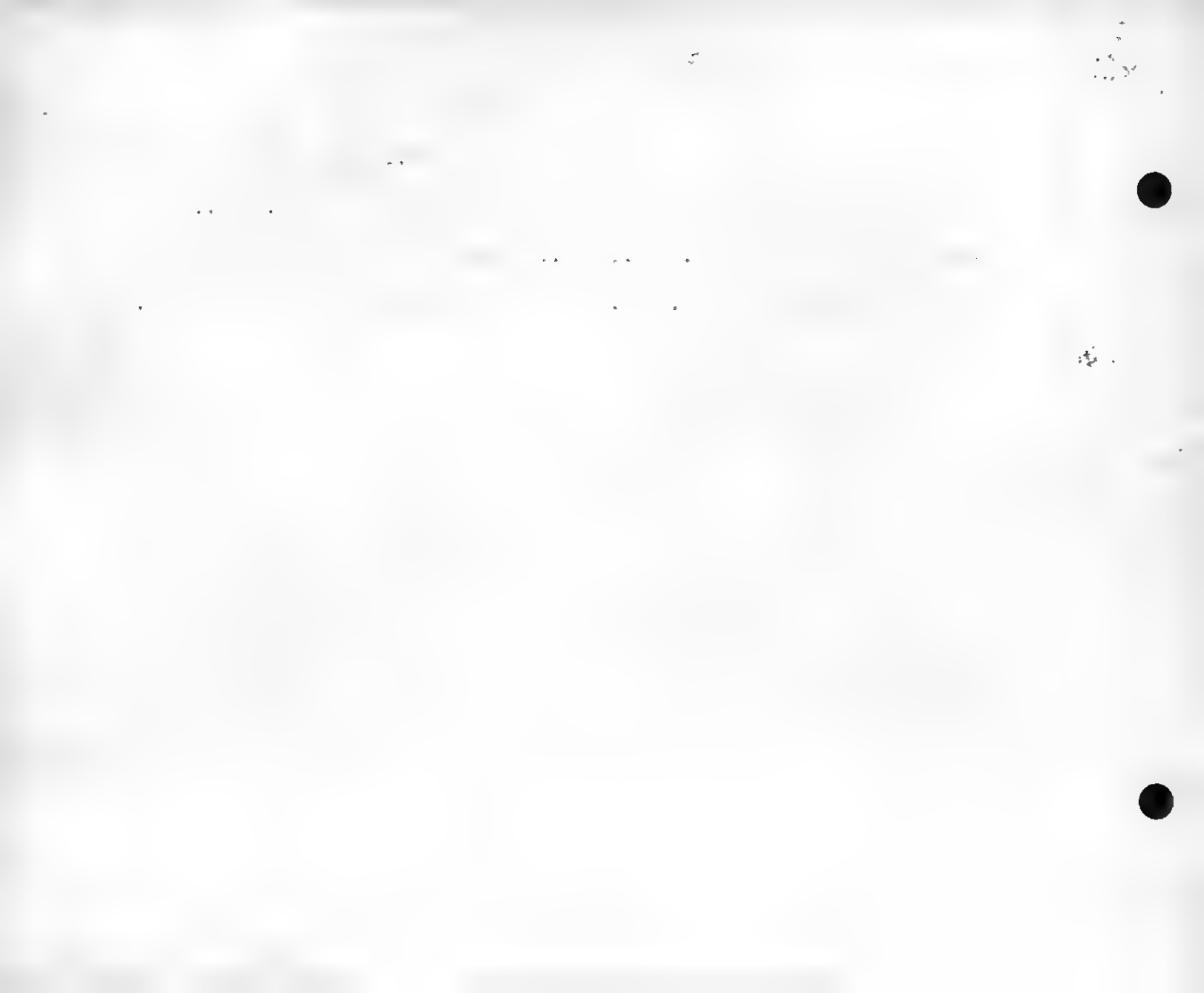




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH			2b. HOUR		
Emma							Joyce		Month July Day 15 Year 68			12.09 PM		
3 SEX		4 RACE		5 DATE OF BIRTH				6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female		White		23 Feb., 1868				79 YRS		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
New York			U.S.A.						Pr. Geo., Md					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly				Pr. Geo., Gen., Hosp										
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admn ssion) STATE				13b COUNTY				13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER		
Maryland				Pr. Geo.				Mitchellsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		816 Villa Rosa Nur. Home		
14 FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				
										First Middle Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO				17 INFORMANT				Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>												2 WEEKS		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral thrombosis</u>												YEARS		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral thrombosis</u>												YEARS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
<u>31X Atherosclerotic heart disease</u>														
19a. DATE OF OPERATION			19b. CONDIT. ON FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)							
			HOUR A.M. Month Day Year 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC				21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>7-14</u> , 19 <u>68</u> , to <u>7-15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Fidel J. Quintana M.D.</u>								DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>7-15-68</u>		
22d. PHYSICIAN'S NAME (Type) <u>FIDEL J. QUINTANA</u>								22e. ADDRESS <u>12004 MAYCHECK LANE, BOWIE, MD.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)	
			<u>7-18-68</u>		<u>ARLINGTON</u>				<u>NAT ARLINGTON</u>				<u>VA.</u>	
24. FUNERAL DIRECTOR <u>Wm. Chambers</u>								ADDRESS <u>1400 - Chapin St. N.W.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
										DATE <u>JUL 17 1968</u>		<u>Charles Judge</u>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Thomas					Joyce	Month Day Year July 13, 1968			6:00AM
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.	
Male		White		7/4/99		69 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		U.S.A.				Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USIA: OCCUPATION (Kind of work done during most of working life, even if casual)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince Geo. Gen. Hosp.			Receiving Clerk			Dept. Store
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince Geo.			Hyattsville		623 Sheridan St.	
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME First Middle Last			
Henry					Joyce	Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT			Address
No			577 03 6303			Alice Joyce			Same as #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Generalized Peritonitis</u>									6 days
DUE TO, OR AS A CONSEQUENCE OF, (b) <u>Delirium of Gastroenterocolitis</u>									6 days
DUE TO, OR AS A CONSEQUENCE OF, (c) <u>Adrenal hemorrhage</u>									6 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Adrenal hemorrhage</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ALTOGETHER YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
7/12/68			Delirium of Gastroenterocolitis					Yes	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			Hour A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION		City or Town County State	
						Street or RFD No			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> , 19 <u>68</u> , to <u>July 13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7/13</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
<u>Jerome L. Sandler</u>						13 July '68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Jerome L. Sandler						106 Irving St., N.W., Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF REPOSITORY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		7/15/68		Ft. Lincoln		Colmar Manor P.G. Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons				Hyattsville, Md.		DATE		7/17 1968	



## CERTIFICATE OF DEATH

10490

1. DECEASED NAME (Type or print) Nellie		First Middle Last J. Kaiser		2a. DATE OF DEATH Month Day Year July 4 1968		2b. HOUR 7:20 PM	
3 SEX Female		4. RACE Cauc.		5. DATE OF BIRTH July 9, 1901		6. AGE (In years at birth) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) E. Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY P. G.		13c. CITY OR TOWN Laurel		13d. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Brookland Bridge Rd.		14. FATHER'S NAME First Middle Last Joseph William Howell		15. MOTHER'S MAIDEN NAME First Middle Last Dora Louise Hauff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address E. Leland Memorial Hosp. 4408 Queensbury Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Previous Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1968</u> to <u>July 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 3, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>Robert L. Winfield M.D.</u>		DEGREE M.D.		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) ROBERT L. WINFIELD M.D.		22e. ADDRESS Laurel, Maryland		22c. DATE SIGNED <u>July 4, 1968</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-8-68		23c. NAME OF CEMETERY OR CREMATORY Loyd Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Laurel Md	
24. FUNERAL DIRECTOR ADDRESS De Witt Sanderson		25a. REC'D BY REGISTRAR JUL 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and page 4, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Selena			--		Kemp	July 7 1968		3:30P	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	Negro		12/28/1902			65 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Va.		U.S.A.				Prince Georges Md			
10. CITY OR TOWN OF DEATH.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Glenn Dale			Glenn Dale Hospital			unknown - retired		unknown	
13a. USUAL RESIDENCE (Where deceased lived, if institutional on admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
					Wash., D.C.			4224 Edson Pl., N. E.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
Richard			--		Gilleson	Lottie		--	Henderson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no			unknown		Decedent				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia, probably due to staphylococci</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Inter-capillary glomerulosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Diabetes mellitus with blindness &amp; neuropathy</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertensive &amp; arteriosclerotic cardiovascular disease; focal encephalomalacia, mild</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION		City or Town County State	
22a. I certify that <del>xx</del> (this hospital) attended the deceased from <u>8/24/</u> 19 <u>66</u> , to <u>7/7/</u> 19 <u>68</u> , that <del>xx</del> (we) last saw the deceased alive on <u>7/7/</u> 19 <u>68</u> , and that in <del>xx</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>xx</del> (we) (did <del>xxxxxx</del> ) view the body after death.									
22b. SIGNATURE <u>Moe Weiss</u>						22c. DATE SIGNED 7/7/1968			
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.						22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 7/13/68		23c. NAME OF CEMETERY OR CREMATORY <u>Hammon Cemetery MD</u>		23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGE MD.</u>		
24. FUNERAL DIRECTOR <u>Taft Williams 4445 Dean Ave NE</u>						25a. RECD BY REGISTRAR JUL 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month 5 Day 68 Year			2b. HOUR 0200M	
James			H Klucker							
3. SEX Male		4. RACE Caucasion		5. DATE OF BIRTH 31 Jan 1932			6. AGE (In years lost birthday) 36 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's County Md			
10. CITY OR TOWN OF DEATH Andrews AFB, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Airman			12b. KIND OF BUSINESS OR INDUSTRY Military		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Michigan		13b. COUNTY Warren		13c. CITY OR TOWN Detroit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 144 69 Hendricks		
14. FATHER'S NAME John Klucker			First	Middle	Last	15. MOTHER'S MAIDEN NAME Elizabeth Harvey			First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO 369 30 0858			17. INFORMANT Mrs. Christine Klucker			Address Same	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 4 JUL 1968 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5 JUL 1968										
19a. DATE OF OPERATION 5 JUL 1968		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (th s hospital) attended the deceased from <u>5 July</u> , 19 <u>68</u> , to <u>5 July</u> , 19 <u>68</u> . That (I) (we) last saw the deceased alive on <u>5 July</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Phineas J. Hyams</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5 July 1968</u>		
22d. PHYSICIAN'S NAME (Type) PHINEAS J. HYAMS, Capt, USAF						22e. ADDRESS Md Malcolm Grow USAF Hosp Andrews AFB				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-8-68		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State) Detroit, Mich			
24. FUNERAL DIRECTOR <u>W. W. Chambers Co. 517-11th St. S.E.</u>						25a. REC'D BY REGISTRAR JUL - 9 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) First Middle Last <b>MAMIE E Klu9</b>					2a. DATE OF DEATH Month Day Year <b>JULY 15 1968</b>		2b. HOUR <b>11:50 PM</b>			
3 SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>11/30/175</b>		6 AGE (In years last birthday) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George</b> Md				
10 CITY OR TOWN OF DEATH <b>Clinton</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Pineview Gardens</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Nurses Aide</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1317 You St. S.E.</b>		
14 FATHER'S NAME First Middle Last <b>Richard Thomas Goddard</b>					15 MOTHER'S MAIDEN NAME First Middle Last <b>Virginia Miller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>579604644T</b>		17. INFORMANT <b>Granddaughter</b>		Address <b>1317 You St S.E. D.C.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>1129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTERIO SCLEROSIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>None</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC.		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>4-5</b> , 19 <b>68</b> , to <b>7-15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-15</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Alfred R. Lapin</b>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7-16-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>ALFRED R. LAPIN, MD</b>					22e. ADDRESS <b>CLINTON, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 17, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Sydney, Maryland</b>				
24. FUNERAL DIRECTOR <b>Wm. B. Brown</b>					ADDRESS <b>1661 Wood Hope Rd</b>		25a. REC'D BY REGISTRAR <b>JUL 17 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #11, Film GLO 2 7/12/68 km									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last Russell Samuel Krout			2a. DATE OF DEATH Month Day Year 7 2 1968			2b. HOUR 150 PM			
3 SEX M		4 RACE W		5. DATE OF BIRTH 12/29/1955		6. AGE (In years last birthday) 12 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Tenn		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Huntsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Huntsville Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) STATE Tenn			13b. CITY OR TOWN WASH. D. C.		13c. INS DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6817 N. 15th St		
14. FATHER'S NAME First Middle Last Samuel M Krout			15. MOTHER'S MAIDEN NAME First Middle Last Mary						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Robert R. Krout (son) 7002 Reynolds Rd. Laurens Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Complete heart block</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Recent C.U.A.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 30, 1968</u> to <u>July 2, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 27, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold W. Draper M.D.			22c. DATE SIGNED July 2, 1968		22d. PHYSICIAN'S NAME (Type) HAROLD W. DRAPER, M.D.				
22e. ADDRESS 9801 GEORGIA AVE, S. River Spring Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 6-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery, Suitland Md.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Arthur Walters			24a. ADDRESS 254 Carroll St		24b. CITY JUL - 18 1968		24c. REGISTRAR'S SIGNATURE Charles Judge		



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>Margaret M. Kuhn</b>			2a DATE OF DEATH <b>July</b> Month <b>8</b> Day <b>68</b> Year			2b HOUR <b>6 P. M.</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>April 17, 1892</b>		6 AGE (In years last birthday) <b>76</b> YRS.	
7a BIRTHPLACE (State or foreign country) <b>Ireland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Hyattsville Nursing Home</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Nurse</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>D.C.</b>		13b COUNTY <b>Wash., D. C.</b>		13c INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e STREET AND NUMBER <b>1708 Newton St., N. W.</b>	
14 FATHER'S NAME First Middle Last <b>Dennis Conroy</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Hannan</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)	
16b SOCIAL SECURITY NO <b>578-26-2029A</b>			17 INFORMANT Address <b>Sil. Spr., Md.</b> <b>Mrs. Mary Kamenjar, Daughter, 9505 N.H. Ave</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary embolism</b> DUE TO, OR AS A CONSEQUENCE OF <b>Chronic Cong. heart failure</b> (b) <b>10 yrs</b> DUE TO, OR AS A CONSEQUENCE OF <b>Minal stenosis &amp; insuffic. circ</b> (c) <b>40 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>410x</b>							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 7, 1968</b> to <b>July 8, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 7, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Thomas F. McMahon M.D.</b> DEGREE				22c DATE SIGNED <b>7-8-68</b>		22d. PHYSICIAN'S NAME (Type) <b>Thomas F. McMahon M.D.</b>	
22e ADDRESS <b>3700 - Conn. Ave. N.W.</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-11-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d LOCAT ON (City or Town) (County) (State) <b>Silver Spring, Montgomery Co Md.</b>	
24 FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.,</b> ADDRESS <b>5130 Wiso. Ave. N.W., Wash., D.C., 20016</b>				25a REC'D BY REGISTRAR <b>JUL 10 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



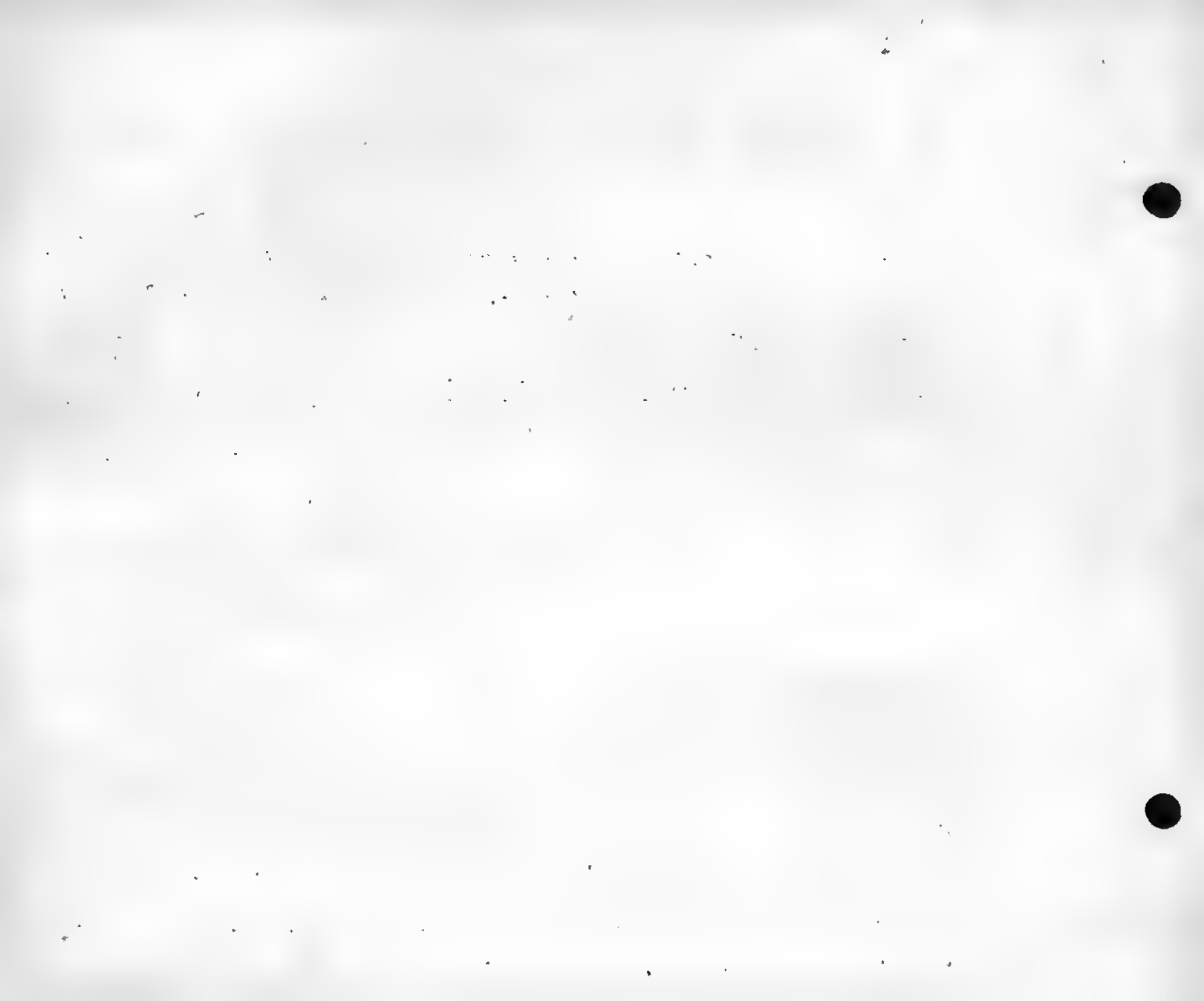


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>THOMAS J. LANAHAN</b>			2a. DATE OF DEATH Month <b>7</b> Day <b>9</b> Year <b>68</b>			2b. HOUR <b>1:55</b> M	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>9-1-78</b>		6. AGE (In years last birthday) <b>89</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>IRELAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md	
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREENBELT Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.) <b>Shipping Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Upstream Electric</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>DC.</b>		13b. COUNTY <b>✓</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>4917 TEL PLACE NE</b>		14. FATHER'S NAME First Middle Last <b>Thomas J. Lanahan</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARIA - Smith</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16b. SOCIAL SECURITY NO <b>577 07 8714</b>		17. INFORMANT (son) <b>Thomas J. Lanahan Jr</b>		Address <b>SAME AS ABOVE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic carcinoma lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sarcoma of Femur</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 yrs</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>196</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>August 19, 1966</b> to <b>7/7/68</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/7/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R.S. Williams MD</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/7/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>R.S. WILLIAMS</b>				22e. ADDRESS <b>35 NEW YORK AVE NW</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>7-10-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley Funeral Home</b>				ADDRESS <b>Mt. Rainier, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
OLIVE			CHRISTINE			LARKINS			Month 7 Day 10 Year 68 8:45AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FEMALE		CAUS.		SEP 26 1891		76 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
ENGLAND		USA				PRINCE GEORGE COUNTY Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR IND. STR.		
CLINTON, MD.			CLINTON COMMUNITY HOSPITAL			Operator of rooming house					
13a. USUAL RESIDENCE (Where deceased lived, if in institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MD.			PR. GEO. CO.			TEMPLE HILLS			5017 BARRY DR.		
4. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Unknown			HALL			Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
NO			?			WAVENEY Higgs			5017 Barry Dr Temple Hills		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerosis</u>										11/17/68	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u>										> 1 Yr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (c) <u>Chronic depression</u>										6 Yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<u>Cerebral Hemorrhage</u> 3 Days											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		19 P.M.									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 7/7, 1968, to 7/10, 1968, that (I) (we) last saw the deceased alive on 7/6/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYS		<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS		22c. DATE SIGNED	
<u>Robert W. Merkle</u>										7/10/68	
22d. PHYSICIAN'S NAME (Type) Robert W. Merkle				22e. ADDRESS							
				116 Mckendree, Brandywine, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial		7/15/68		Cedar Hill Cemetery				Suitland, Prince Georges, Md.			
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
4308 Suitland Road, Suitland, Maryland						DATE JUL 17 1968		<u>Charles J. Gage</u>			



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print) <b>Park</b>			First Middle Last <b>-- -- Lee</b>			2a. DATE OF DEATH Month Day Year <b>July 2 1968</b>		2b. HOUR <b>4:00PM</b>		
3 SEX <b>Male</b>		4 RACE <b>Oriental</b>		5 DATE OF BIRTH <b>2/12/1902</b>		6 AGE (in years last birthday) <b>66</b> YRS		7 UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>China??</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince Georges</b> Md.				
10. CITY OR TOWN OF DEATH <b>Glenn Dale</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Glenn Dale Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>unknown - retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN <b>Wash., D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>805 6th St., N. W.</b>	
14 FATHER'S NAME First Middle Last <b>Fook -- Lee</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mache -- Lee</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>579-66-2703</b>		17 INFORMANT Address <b>Decedent</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>unknown</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Parkinson's disease.</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>1/26/</u> 19 <u>68</u> , to <u>7/2/</u> 19 <u>68</u> , that <del>we</del> (we) last saw the deceased alive on <u>7/2/</u> 19 <u>68</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>the</del> (we) (did) <del>not</del> view the body after death.										
22b. SIGNATURE <i>Moe Weiss</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7/2/68</b>						
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>7-14-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyattsville, Md. Prince Georges Co. P.G.</b>				
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b> ADDRESS <b>300-4th St. N.E. Wash. D.C. 20002</b>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				
				DATE <b>JUL 12 1968</b>						



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <b>GEORGE</b>		First		Middle		Last		2a DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> Month <b>July</b> Day <b>4</b> Year <b>1968</b>		2b HOUR <b>5</b> M		
3 SEX <b>M</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>June 6 28 40</b>		6 AGE (in years last birthday) <b>28</b> YRS		F UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>		2c DATE PRONOUNCED DEAD Month <b>July</b> Day <b>4</b> Year <b>1968</b>		
7a BIRTHPLACE (State or foreign country) <b>Washington</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George</b> Md						
10 CITY OR TOWN OF DEATH <b>Chesley</b>		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo General Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if not in hospital address) STATE <b>MD</b>		13b COUNTY <b>Prince George</b>		13c CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3970 Pennsylvania</b>				
14 FATHER'S NAME <b>John E Leissler</b>				First		Middle		Last		15 MOTHER'S MAIDEN NAME <b>Ruth Callen</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>wife Myra Leissler</b>		ADDRESS <b>3931 Pennsylvania Washington</b>						
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION <b>7-7-68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No <b>3970</b> City or Town <b>Washington</b> County <b>Prince George</b> State <b>MD</b>								
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Dayton O Watkins</b>		EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <b>7-7-68</b>		
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE <b>7-7-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d LOCATION (City or Town, State) <b>Jacksonville, Florida</b>						
24 FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Rd. SE, Suitland, Maryland</b>						25a. REC'D BY REGISTRAR <b>JUL 16 1968</b>		25b REGISTRAR'S SIGNATURE <b>J Charles Judge</b>				





CERTIFICATE OF DEATH

10491

10500

1 DECEASED-NAME (Type or print) <i>DIANA Lynn Long</i>			2a. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1968</i>			2b. HOUR <i>2030</i>				
3 SEX <i>Female</i>		4 RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>31 July 1968</i>		6 AGE (In years lost birthday) YRS MONTHS DAYS <i>0 0 18</i>		IF UNDER 1 YEAR IF UNDER 24 HRS		
7a. BIRTHPLACE (State or foreign country) <i>AAFB Hosp</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges Md.</i>				
10 CITY OR TOWN OF DEATH <i>AAFB Hosp.</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Malcom Grow USAF Hosp</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUA. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Prince Georges</i>		13c. CITY OR TOWN <i>AAFB Hosp</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>AAFB Hospital</i>		
14 FATHER'S NAME First <i>JAY</i> Middle <i>HUE</i> Last <i>Long</i>			15 MOTHER'S MAIDEN NAME First <i>GAYNELL</i> Middle <i>Mc</i> Last <i>Millan</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>			16b. SOCIAL SECURITY NO. <i>---</i>		17 INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO-RESPIRATORY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>IMMATUREITY</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hr 18 min</i> <i>0'</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>---</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>31 July, 1968</i> , to <i>31 July, 1968</i> , that (I) (we) lost saw the deceased alive on <i>31 July</i> 1968, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Richard W. Dodds MD</i> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>31 Jul 68</i>				
22d. PHYSICIAN'S NAME (Type) <i>RICHARD W. DODDS</i>				22e. ADDRESS <i>Malcom Grow USAF Hosp, Andrews AFB</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>8-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Belmont National</i>		23d. LOCATION (City or Town) (County) (State) <i>Belmont, Prince Georges, Md.</i>				
24. FUNERAL DIRECTOR Address <i>W. W. Chambers Co. 517-11 St. S.E.</i>				25a. REC'D BY REGISTRAR DATE <i>AUG 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. The people remove carbon pages. Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGES COUNTY HOSPITAL</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MORNINGSIDE MARYLAND</u> d. STREET ADDRESS <u>217 PINE GROVE DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CHARLES</u> <u>MICHAEL</u> <u>LUCAS</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>JULY</u> <u>8</u> <u>1968</u>		
<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u>			<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>10/16/1914</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>53</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ill.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Martin Lucas</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>EDNA LUCAS</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> Address <u>EDNA LUCAS</u> <u>217 PINE GROVE DR MORNINGSIDE</u>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause, but line for (e), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4109</u> DUE TO <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Hour e.m. p.m. Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Mar. 12, 1963</u> <b>to</b> <u>July 8, 1968</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Mar 25, 1968</u> , <b>and that death occurred at</b> <u>7:20 P.M.</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Frank S. Pellegrini</u> <b>M.D.</b> <b>22b. DATE SIGNED</b> <u>7.8.68</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>FRANK S. PELLEGRINI</u> <b>22d. ADDRESS</b> <u>3611 Branch Ave NE Wash DC 20031</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>7/11/68</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lee's Crematorium</u>	
<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington, D. C.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b> <u>Lee Funeral Home</u> <u>Washington, D. C.</u>			
<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>JUL 11 1968</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

10502

1. DECEASED NAME (Type or print) <b>Daniel</b>			First <b>J.</b> Middle <b>Lynch</b> Last			2a. DATE OF DEATH Month <b>1</b> Day <b>2</b> Year <b>1968</b>			2b. HOUR <b>12:30</b> M								
3 SEX <b>Male</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>3/13/72</b>			6. AGE (In years last birthday) <b>2</b> YRS			7. UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			8. UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Ireland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b> Md								
10. CITY OR TOWN OF DEATH <b>Riverdale</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Stith Memorial</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Prince Geo's</b>			13c. CITY OR TOWN <b>Hyattsville</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER <b>3301 Manorwood Dr.</b>					
14. FATHER'S NAME <b>Unknown</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>Unknown</b>			First Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>265-34-2934</b>			17. INFORMANT <b>Charles Decker Son-in-law</b>			Address <b>Same as above</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septic shock and shock.</b> DUE TO, OR AS A CONSEQUENCE OF <b>Secondary amnesia.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Quarteculosis of colon.</b> (b) <b>Quarteculosis of colon.</b> DUE TO, OR AS A CONSEQUENCE OF <b>Quarteculosis of colon.</b> (c) <b>Quarteculosis of colon.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>3 days</b>					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>June 3, 1968</b> , to <b>July 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>[Signature]</b>			DEGREE <b>MD</b>			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Type) <b>Removal</b>			23b. DATE <b>7/4/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Stith Funeral Home</b>			23d. LOCATION (City or Town) (County) (State) <b>Danville Kentucky</b>								
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Maryland</b>			25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>								



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #5&6 11/21/68 taken from [unclear] cert. V.P.

## CERTIFICATE OF DEATH

703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>None</u> Pr. Geo. Co. MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine Md.</u> c LENGTH OF STAY IN 1b <u>Life time</u> d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Co.</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Brandywine Md.</u> b COUNTY <u>Prince George</u> c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linnette Road</u> d STREET ADDRESS <u></u> e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>BESSIE</u> First <u>ALBERTA</u> Middle <u>MAHONEY</u> Last				4 DATE OF DEATH <u>JULY</u> Month <u>23</u> Day <u>19</u> Year <u>68</u>			
5 SEX <u>Female</u>		6 CO. OR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>9/2/1905</u>	
				9 AGE (In years last birthday) <u>62</u> yrs.		10 IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <u>Brandywine Md.</u>	
						12 CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13 FATHER'S NAME <u>Herbert Albert Young</u>				14 MOTHER'S M maiden NAME <u>Janie Dorenda Butler Young</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO <u>579-44-6583</u>		17 INFORMANT <u>Alberta Mahoney - Danville Rd. Brandywine Md.</u> Address <u></u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TERMINAL BRONCHOPNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>METASTATIC CARCINOMA CERVICAL SPINE</u> 6 MONTHS DUE TO (c) <u>UNKNOWN PRIMARY</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1, 1967</u> , to <u>JULY 23, 1968</u> , that (I) (not) last saw the deceased alive on <u>July 23, 1968</u> , and that death occurred at <u>3 P.M.</u> , from causes and on the date stated above.							
22a SIGNATURE <u>Thomas S. Sappington</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 23, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS S. SAPPINGTON</u>				22d. ADDRESS <u>2233 WISCONSIN AVE. NW, WASH. D.C.</u>			
23a. BURIAL, CREMATION, REMOVA. (Specify)		23b. DATE THEREOF <u>July 21, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Brandywine Pr. Geo. Co. Md.</u>	
24 FUNERAL DIRECTOR <u>Harrell Adams</u> ADDRESS <u>Crownsville Md.</u>				25a REC'D BY REGISTRAR <u>JUL 30 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon plates 1 and 2. Should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

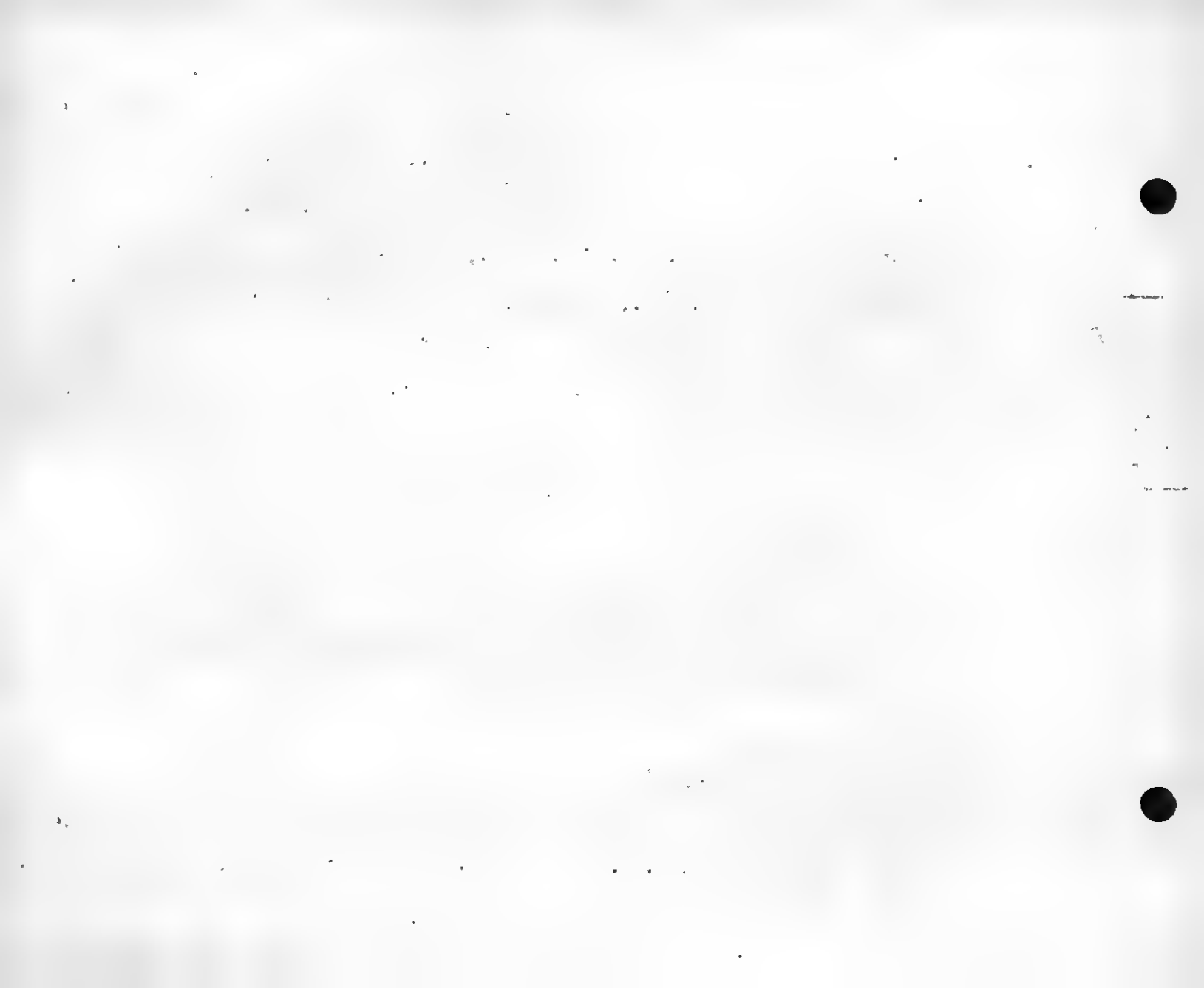
1. DECEASED NAME (Type or print) <b>Charles D. Mandes</b>			2a. DATE OF DEATH <b>July</b> Month <b>6</b> Day <b>1968</b> Yr		2b. HOUR <b>10<sup>20</sup> A.M.</b>
3 SEX <b>male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>unknown</b> <b>1881</b>		6 AGE (In years last birthday) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Greece</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b> Md.		
10. CITY OR TOWN OF DEATH <b>Lanham</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>magnolia Gardens Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>retired owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>D.C.</b>	13b. COUNTY <b>Wash. D.C.</b>	13c. CITY OR TOWN <b>Wash. D.C.</b>	13d. INSIDE CITY (Y/N) <b>YES</b> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>1416-15th Street</b>	
14. FATHER'S NAME First <b>Demetrios</b> Middle <b>Mandes</b> Last <b>Mandes</b>		15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>577-48-8026</b>		17. INFORMANT <b>Dr. James Mandes</b> <b>1355 2nd St. N.W. Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>2001</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Debris in Wall of Heart</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)	
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>7-4-68</b> , 19 <b>68</b> , to <b>7-6</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-4</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Rafael C. Lee M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>7-6-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>RAF. Rafael C. Lee M.D.</b>				22e. ADDRESS <b>426 Irvington St SE, Orono Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>July 10, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Clawson Cemetery</b>	
23d. LOCATION (City or Town) <b>Washington, D.C.</b> (County) (State)		23e. ADDRESS <b>426 Irvington St SE, Orono Md.</b>		23f. ADDRESS <b>Silver Spring, Md.</b>	
25a. REC'D BY REGISTRAR <b>JUL 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Rose			M		Marean	July 30 1968			3:45 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		10 Oct., 1912		55		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington, DC		U S A				Pr. Geo.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Pr. Geo. Gen. Hosp.		housewife		None			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Pr. Geo.		Landover		YES <input type="checkbox"/> NO <input type="checkbox"/>		7411 Buchanan Street
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Claude			Petrone			Madoline Storty			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17 INFORMANT		Address		
No			None		579221448		Raymond F. Marean Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> 157.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
									20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1968</u> , to <u>July 30, 1968</u> , that (I) (we) saw the deceased alive on <u>July 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS		22c. DATE SIGNED	
Robert Deitz, M. D.						Prince George's Plaza, Hyattsville, Md.		July 30, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		8/2/1968		Gate of Heaven Cem.		Silver Spring, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Valley Funeral Home Mt. Rainier, Md.						DATE AUG 2 1968		J. Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print) <i>Vaile Jackson M. Daniel</i>						2a DATE KNOWN OF ESTIMATED DEATH <input checked="" type="checkbox"/> Month <i>7</i> Day <i>1</i> Year <i>1968</i>		2b HOUR <i>M</i>			
3 SEX <i>M</i>		4 RACE <i>W</i>		5 DATE OF BIRTH <i>Dec 5 1924</i>		6 AGE (In years last birthday) <i>43</i>		7 IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		8 IF UNDER 24 HRS HOURS <i></i> MIN <i></i>	
7a BIRTHPLACE (State or foreign country) <i>Virginia</i>			7b CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Prince Georges</i>		
10 CITY OR TOWN OF DEATH <i>Chesley</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Prince Georges Dist. Hospital</i>				12a USUAL OCCUPATION (Kind of work done, and most of working life, even if retired) <i>major warehouse food</i>		12b KIND OF BUSINESS OR INDUSTRY <i></i>	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>MD</i>				13b COUNTY <i>Pr. Geo. Coral Hills</i>				13c CITY OR TOWN <i></i>		13d INSIDE CITY limits? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
13e STREET AND NUMBER <i>5215 Horner</i>				14 FATHER'S NAME First <i>Jackson M. Daniel</i> Middle <i></i> Last <i></i>				15 MOTHER'S MAIDEN NAME First <i>Ruth Davis</i> Middle <i></i> Last <i></i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16b SOCIAL SECURITY NO <i>578288440</i>				17 INFORMANT <i>Betty Homer Suitland</i> ADDRESS <i>Brookside Dr</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis few minutes</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Coronary Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i></i>											
19a DATE OF OPERATION <i></i>						19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <i></i>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i></i>				21b TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M. <i></i>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i></i>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i></i>				21f LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Dayton O Walker</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>DAYTON O WALKER</i>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county) <i>5318 Annapolis Rd, Beadlinshy, Md</i>					
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b DATE <i>7-5-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>				23d LOCATION (City or Town) (County) (State) <i>PG County, Maryland</i>	
24 FUNERAL DIRECTOR <i>Wilhelm Funeral Home</i> ADDRESS <i>4308 Suitland Road, SE, Suitland, Maryland</i>						25a REC'D BY REGISTRAR <i>JUL 11 1968</i>		25b REGISTRAR'S SIGNATURE <i>J Charles Judge</i>			



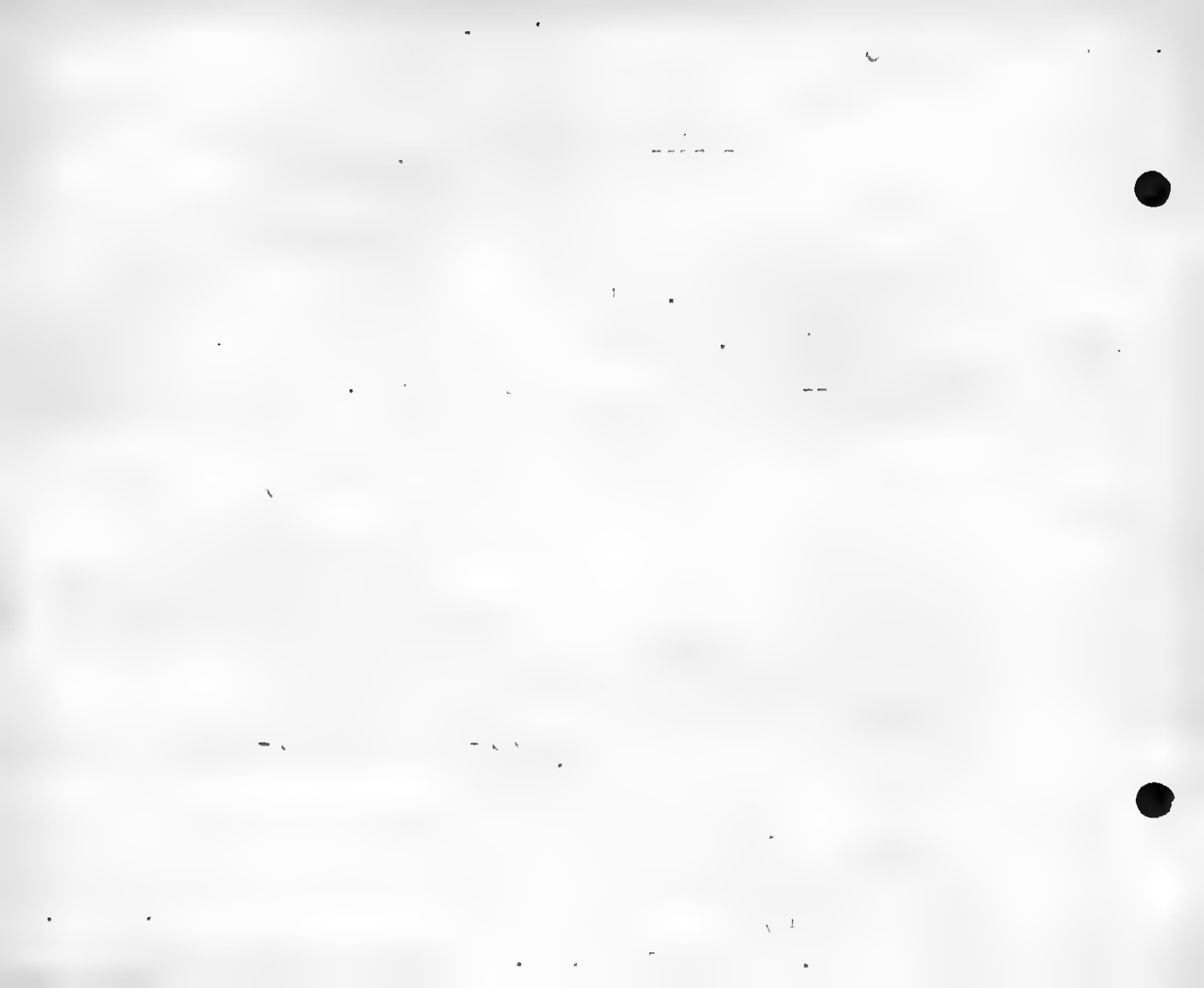
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>MARY</b>			First Middle Last <b>M McGREGOR</b>			2a. DATE OF DEATH Month Day Year <b>7 15 1968</b>			2b. HOUR <b>10<sup>30</sup>A.</b>		
3 SEX <b>FEMALE</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>7/28-1879</b>			6. AGE (In years lost birthday) <b>88</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince Georges</b> Md		
10. CITY OR TOWN OF DEATH <b>Forestville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Regent 2nd Mch. Center</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housekeeper</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo's</b>			13c. CITY OR TOWN <b>Berksshire</b>			13e. STREET AND NUMBER <b>7310 ENSLEY ST.</b>		
14. FATHER'S NAME First Middle Last <b>Roderick M. McGregor</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth -- Bowie</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>---</b>		
17 INFORMANT Address <b>Miss Grace M. Wood-Same as Item 13-e</b>			18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 Yrs.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>7</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-5</b> , 19 <b>66</b> , to <b>7-15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-15</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W B Sheer M.D.</b>			DEGREE <b>M.D.</b>			ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <b>July 15, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>WALTER B. SHEER</b>			22e. ADDRESS <b>6400 MARLBORO PIKE, WASH. D.C.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/18/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Forestville Pr. Geo Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Ritchie Bros. Upper Marlboro, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JUL 24 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J Charles Jones</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b HOUR
John			McKnight			July Month 6 Day 1968 Year			10 A M
3. SEX		4. RACE		5 DATE OF BIRTH			6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
Male		White		13 April 1902			66 YRS		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Maryland		U.S.A.					Prince George's Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Riverdale			6207 44th. Ave.			Chief Eng.			U of Md.
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Pr. Geo.		Riverdale			6207 - 44th. Avenue	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Robert			McKnight			Annie Meun			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17. INFORMANT Address				
No			248-20-1432		Margaret McKnight-6207-44th. Ave., Riverdale, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma with metastasis to brain</b>									2 yrs.
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
1621 <b>Pulmonary emphysema</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) <del>(did not)</del> attended the deceased from <b>14 July</b> , 19 <b>59</b> , to <b>6 July</b> , 19 <b>68</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>2 July</b> , 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(did)</del> <b>(did)</b> view the body after death.									
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED	
								6 July 1968	
22d. PHYSICIAN'S NAME (Type)					22e ADDRESS				
William B. Gunther, M. D.					4917 Edgewood Road, College Park, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		7/10/68		LOUDON PARK CEMETERY		BALTIMORE MARYLAND			
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
F. GASCH'S SONS			HYATTSVILLE, MD.			JUL 11 1968			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print) <b>LEO ROSCOE MC MATTON</b>			First Middle Last			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>July 6 1968</b>		2b HOUR <b>M</b>	
3 SEX <b>M</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>Feb 7 1906</b>	6 AGE (in years last birthday) <b>62</b>	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month <b>July</b> Day <b>6</b> Year <b>1968</b>	
7a BIRTHPLACE (State, or foreign country) <b>Washington DC</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince Georges</b>		2d HOUR <b>M</b>	
10 CITY OR TOWN OF DEATH <b>Riverdale</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Eugene Leeland Memorial Auditorium Building</b>		12a USUAL OCCUPATION (Kind of work done during last 12 months, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution, on Residence before admission) STATE <b>Md</b>		13b COUNTY <b>Pr Georges</b>		13c CITY OR TOWN <b>MT Rainier</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>3803-37 St</b>	
14 FATHER'S NAME First Middle Last <b>Roscoe Mc Mahon</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Wilhelmina Souer</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b SOCIAL SECURITY NO <b>578 05 8347</b>		17 INFORMANT <b>Charles Mc Mahon son of</b>		ADDRESS <b>9326 Weymouth</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>								<b>inst</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary arteriosclerosis</b>									
DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Dayton O Watkins</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>7-8-68</b>		22b DATE SIGNED					
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5318 Annapolis Rd</b>					
		ADDRESS (Street, city, town, or county) <b>Beadmontary Rd</b>							
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE <b>7-9-1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d LOCATION (City or Town) <b>Calmar Manor Md</b>		(County) (State)	
24 FUNERAL DIRECTOR <b>Valley Funeral Home</b>				ADDRESS <b>MT Rainier Md</b>		25a READ BY REGISTRAR <b>JUL 11 1968</b>		25b REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

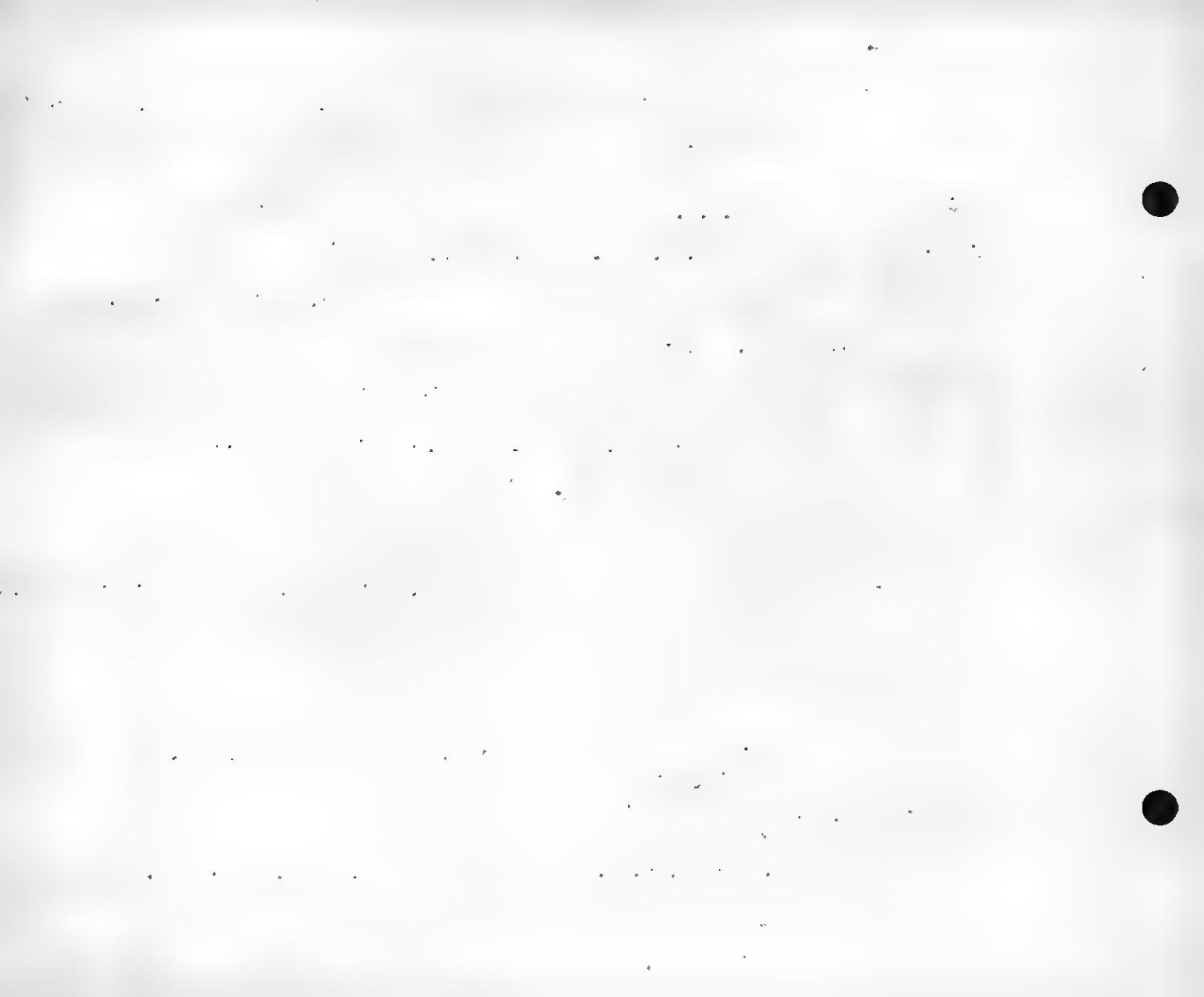


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <div style="display: flex; justify-content: space-around;"><span>First <b>Baby</b></span><span>Middle <b>Boy</b></span><span>Last <b>Meredith</b></span></div>			2a. DATE OF DEATH <b>July</b> Month <b>9</b> , Day <b>1968</b> Year		2b. HOUR <b>4:03P</b>	
3 SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>July 7, 1968</b>		6. AGE (In years lost birthday) YRS <b>2</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince. Geo.Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) - STATE <b>Maryland</b>	13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>12211 Millstream Drive</b>		
14. FATHER'S NAME First Middle Last <b>David G. Meredith</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Barbara Ewell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Hospital Records</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Distress Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Prematurity</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>Pulmonary Distress syndrome due to Prematurity, 1640 grams; Atelectasis Neonatorum</b>						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <del>did not</del> attended the deceased from <b>July 7, 1968</b> , to <b>July 9, 1968</b> , that (I) <del>we</del> saw the deceased alive on <b>July 9, 1968</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> (did) <del>not</del> view the body after death.						
22b. SIGNATURE <b>John H. Moling, M.D.</b>			DEGREE - ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <b>July 9, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>John H. Moling, M.D.</b>			22e. ADDRESS <b>12107 Linden Lane, Bowie, Md. 20715</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>7-11-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery Baltimore, Md.</b>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR ADDRESS <b>Valley Funeral Home Mt. Rainier, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>JUL 12 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

30M RE 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month	
Michael			F		Miller		July 21		2b. HOUR 1:30 PM	
3 SEX MALE			4. RACE White			5. DATE OF BIRTH Jan. 16, 1952			6. AGE (in years last birthday) 16 YRS.	
7a. BIRTHPLACE (State or foreign country) Washington D C			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Cheserky Chervery			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George General			2a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Student			12b. KIND OF BUSINESS OR INDUSTRY School	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md			13b. COUNTY Prince George Landover Hills			13c. CITY OR TOWN Hills			13d. STREET AND NUMBER 7403 Parkwood St.	
14. FATHER'S NAME John R. Miller			15. MOTHER'S M.A.DEN NAME Ruth D Carter			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no			16b. SOCIAL SECURITY NO.	
17. INFORMANT John R Miller			Address Landover Hills, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Acidosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchiectasis and Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypo gamma Globul anemia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 4 Years 16 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1968</u> , to <u>July 21, 1968</u> , that (I) (we) lost saw the deceased alive on <u>July 21, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Thomas G. Maloney MD</u>						22c. DATE SIGNED <u>21 July 68</u>			22d. PHYSICIAN'S NAME (Type) Thomas G. Maloney, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE July 24, 1968			23c. NAME OF CEMETERY OR REMOVAL Washington National	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR JUL 26 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Nancy</b>			First <b>I.</b> Middle <b>Miller</b> Last			2a. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1968</b>		2b. HOUR <b>6:25 A.M.</b>		
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>1-14-96</b>		6. AGE (in years last birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>12</b> HOURS <b>12</b> MIN		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>PG</b>		13c. CITY OR TOWN <b>Kent Village</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>7216 Hawthorne Terrace</b>	
14. FATHER'S NAME First <b>E.</b> Middle <b>Moore</b> Last			15. MOTHER'S MAIDEN NAME First <b>Price</b> Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>577014228</b>		17. INFORMANT Address <b>Percy C. Miller, Same as #13 (Husband)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Interosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4109</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>3 yrs</b> <b>3 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4109</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>October 1960</b> , to <b>July 27, 1968</b> , that (I) (we) lost saw the deceased alive on <b>July 25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>William D. Rosson M.D.</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/29/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>William D. Rosson</b>				22e. ADDRESS <b>5701 85th Ave., New Carrollton, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>				
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Rd. SE, Suitland, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



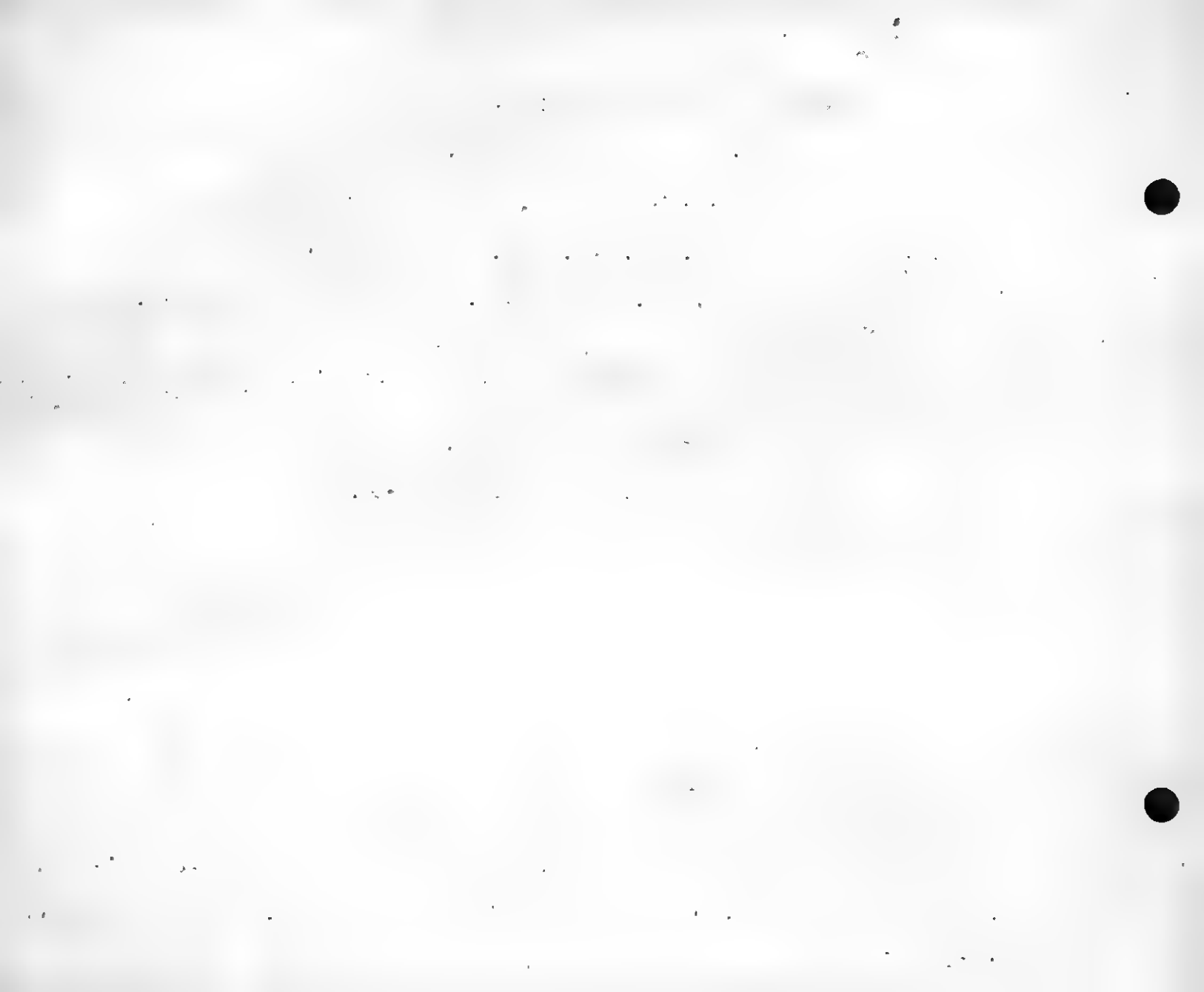
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

10504

10513

1. DECEASED NAME (Type or print) <b>Jean (nmn) Milligan</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>68</b>			2b. HOUR <b>6:20AM</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>30 June 1896</b>		6 AGE (In years lost birthday) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Scotland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.					
10 CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo. Gen. Hosp.</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Pr. Geo.</b>		13c CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>5506 43rd Ave.,</b>		
14 FATHER'S NAME First Middle Last <b>Boyd Bryson</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Helen Wilson</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-26-5434</b>		17 INFORMANT <b>Mr. Alexander Milligan</b> Address <b>13109 Flint Rock Dr Calverton, Beltsville, Md.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart failure.</b> <b>1129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <b>1967</b> to <b>July 9, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>Donald C. Edgren</b>		DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7-9-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>DONALD C. EDGREN</b>		22e. ADDRESS <b>Prince George's Plaza, Hyattsville, Md.</b>									
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		23b. DATE <b>July 12, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pr. Geo. Md.</b>				
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>					ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>ROY DANIEL MOORE</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>July</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>11:15 AM</b>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>Jan 17 1913</b>	6. AGE (In years last birthday) <b>55</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	2c. DATE PRONOUNCED DEAD Month <b>July</b> Day <b>7</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>NC USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Gen Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		
13a. USUAL RESIDENCE (Where deceased lived, if not in institution, give street address) STATE <b>Md</b>		13b. CITY OR TOWN <b>Forestville</b>		13c. INSIDE CITY OR TOWN? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>3520 - 79th St</b>		
14. FATHER'S NAME First <b>Daniel</b> Middle <b>Edgar</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Leta</b> Middle <b>Jones</b> Last <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>wife Rubelle Moore</b> ADDRESS <b>3520 - 79th St Forestville Md</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>instant</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4109</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b></b>								
19a. DATE OF OPERATION <b></b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b></b>		21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b></b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b></b>		21f. LOCATION: Street or R.F.D. No <b></b> City or Town <b></b> County <b></b> State <b></b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Dayton O Watkins</b>		M.D. <b></b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>7-7-68</b>		
EXAMINER'S NAME (Type) <b>DAYTON O. WATKINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5318 Annapolis Rd</b>		
				ADDRESS (Street, city, town, or county) <b>Beaumont Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-10-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>		23d. LOCATION (City or Town) <b>Farmville N.C.</b> (County) <b></b> (State) <b></b>		
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b> ADDRESS <b>300 - H ST NE D.C.</b>				25a. REC'D BY REGISTRAR <b>JUL 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>Eleanora Ramona Moy</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1968</b>			2b. HOUR <b>8:50</b> P.M.			
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 4, 1887</b>		6 AGE (In years lost birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George</b> Md			
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sacred Heart Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>7151 Cipriano Road</b>	
14. FATHER'S NAME First <b>Theodore</b> Middle <b>Marsh</b> Last <b>Hardy</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Alice</b> Last <b>Russell</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>219-547-7769</b>		17. INFORMANT Address <b>Sacred Heart Home, Hyattsville, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Indurative Carcinoma of the Thyroid</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 year</b> <b>10 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>6 Jul 1968</b> , to <b>21 Jul 1968</b> , that (I) (we) last saw the deceased alive on <b>21 July 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Thomas G Maloney MD</b>				22c. DATE SIGNED <b>21 July 68</b>		22d. PHYSICIAN'S NAME (Type) <b>Thomas G Maloney</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington D C</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR
Ethel Ann Mudd						7 20 1968			10:25 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2c. DATE PRONOUNCED DEAD Month Year			2d. HOUR
F	W	10 Aug 1942	25 YRS			7 20 1968			11:00 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MD		USA				Prince George Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during part of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Clinton			Clinton Hosp.			DOMESTIC			HOUSEWIFE
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER
Md			Prince George Clinton						8522 Delano Drive
14. FATHER'S NAME First Middle Last			15. MOTHER'S MIDDLE NAME First Middle Last						
JOSEPH MASON JOHNSON			ZULEMIA POSEY JOHNSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No						JOE MUDD WALDORE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic shock DUE TO, OR AS A CONSEQUENCE OF (b) Laceration of neck DUE TO, OR AS A CONSEQUENCE OF (c) Minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 10:25 AM 7 20 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) Passenger in car involved in collision			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street			21f. LOCATION Street or R.F.D. No City or Town County State St. rt. 5 1/2 mile north of Suratts Rd P.G. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John Kehoe, M.D., Riverdale			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, OR REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			
BURIAL			7-25-1968			St. PETERS			
24. FUNERAL DIRECTOR			25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
To Untt FUNERAL Home, WALDORE, MD			DATE JUL 26 1968			J Charles Judge			

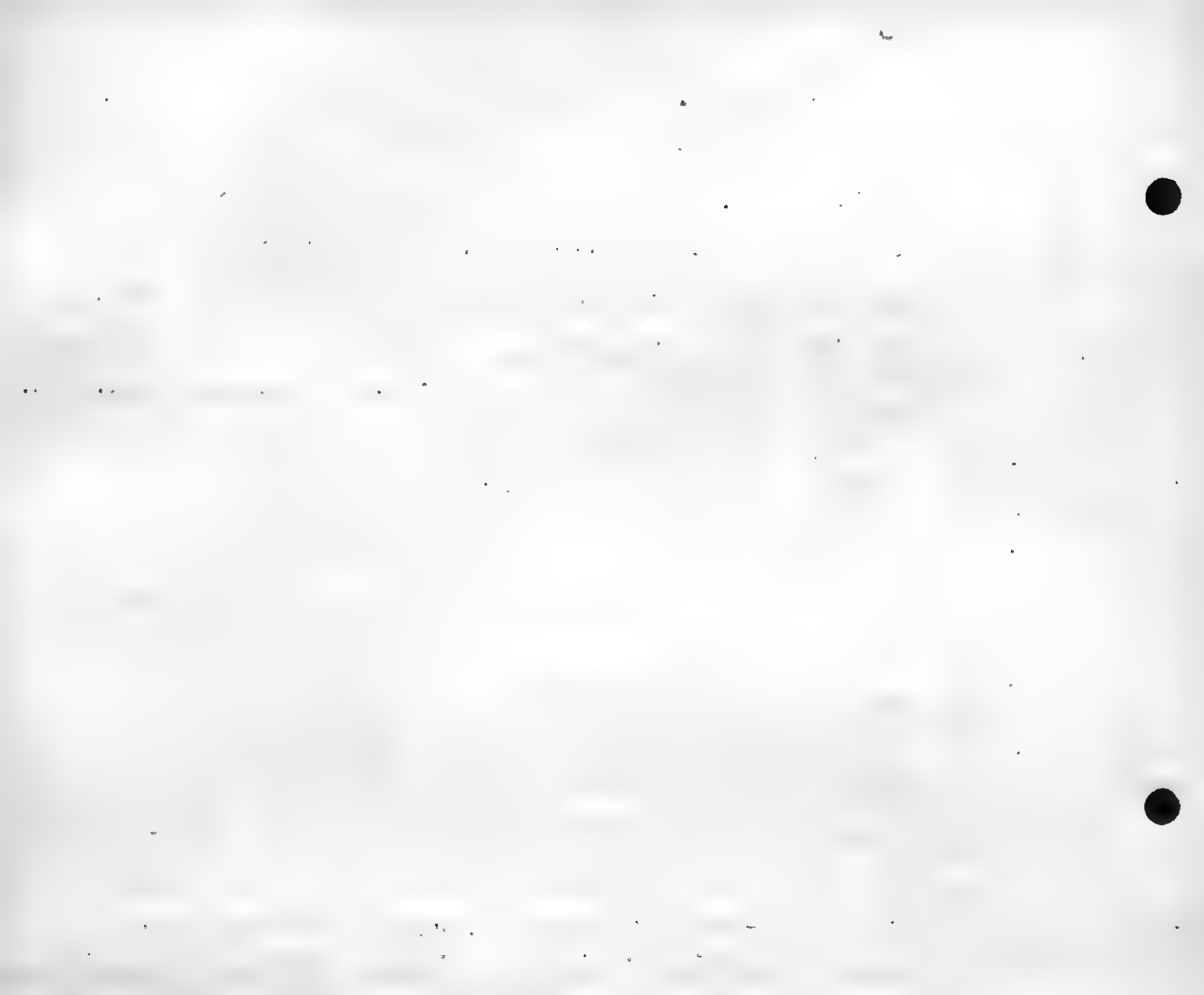


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Do not remove without official approval.*

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Charles W. Mullen</b>			2a. DATE OF DEATH <b>July</b> Month <b>12</b> Day <b>1968</b>			2b. HOUR <b>9:25 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 13 1908</b>		6. AGE (In years lost birthday) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Wash, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>713 Rittenhouse St.</b>		12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired) <b>Far tender</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Far</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>713 Rittenhouse St.</b>	
14. FATHER'S NAME First Middle Last <b>Charles Mullen</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Nellie Flaherty</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>es</b>		16b. SOCIAL SECURITY NO <b>1945 578 01 0947</b>		17. INFORMANT Address <b>Nellie Mullen 713 Rittenhouse St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>151x</b>									
19a. DATE OF OPERATION <b>151x</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 6, 1968</b> to <b>July 12, 1968</b> , that (I) (we) lost the deceased on <b>July 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John F. Finneyan M.D.</b>		22c. PHYSICIAN'S NAME (Type) <b>John F. Finneyan M.D.</b>		22d. ADDRESS <b>1746 K St. N.W. Wash. D.C.</b>		22e. DATE SIGNED <b>July 12, 1968</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>7-15-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>Valley Funeral Home</b>		ADDRESS <b>Nt. Rainier, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Leo J. Myzick (Mozdziak)			Leo	J.	Myzick (Mozdziak)	Month 7 Day 13 Year 1968		4:00A	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		Dec. 19, 1919		48 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Pa.		U S A				Prince George's Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION WHERE DECEASED DIED			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George General			Sales Manager		Sears	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.			P.G.			College Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER			13f. STREET AND NUMBER						
10101 52nd Avenue									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Joseph Myzick			Stella Klimchak						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes, give number or date of service)			17 INFORMANT Address			
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			WW 11			207-03-8484 Emma J. Myzick Same as #13			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sub-ARACHNOID Hemorrhage</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ANeurism</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
330x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or RFD No City or Town County State				
While <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 7-10, 1968, to 7-13, 1968, that (I) (we) last saw the deceased alive on 7-12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED
C. Deitz, M.D.									7-13-68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Aaron Deitz, M. D.					Prince George Plaza Hyattsville, Md.				
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/15/68		Gate of Heaven		Silver Spring Montg. Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REGD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis Gasch's Sons Hyattsville, Maryland					JUL 17 1968		[Signature]		

Franc Gasch's Sons Hyattsville, Maryland  
Burial 7/12/68 Gate of Heaven

Silver Spring P. O. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED-NAME (Type or print)			First <b>Leslie</b>			Middle <b>Norfolk</b>			2a. DATE OF DEATH Month <b>4</b> , Day <b>1968</b> Year			2b. HOUR <b>9:05P</b> M	
3 SEX <b>Male</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH <b>2/28/95</b>			6. AGE (In years last birthday) <b>73</b> YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS M.N.	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Prince George's</b> Md				
10 CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired-Pepco</b>			12b KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Prince George's</b>			13c CITY OR TOWN <b>Seat Pleasant</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>518 67th Place</b>	
14. FATHER'S NAME First Middle Last <b>Samuel Norfolk</b>			15 MOTHER'S MAIDEN NAME- First Middle Last <b>Katie Trott</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b SOCIAL SECURITY NO <b>577-05-0342</b>			17. INFORMANT Address <b>7-13e</b> <b>Edna Jean Norfolk-daughter Same as</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Nutritional Cirrhosis of the liver with hepatic failure.</b> <b>5/1/68</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Broncho-pneumonia, right lung.</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-6 months</b> <b>1 month</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State							
22a I certify that (I) <del>this hospital</del> attended the deceased from <b>Jan 15</b> , 19 <b>68</b> , to <b>July 4</b> , 19 <b>68</b> , that (I) <del>was</del> saw the deceased alive on <b>July 4</b> , 19 <b>68</b> , and that in (my) <del>low</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.													
22b SIGNATURE <b>William Brainin</b> DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c DATE SIGNED <b>7/5/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>WM BRAININ</b> <b>Peter Duus, M. D.</b>						22e ADDRESS <b>6056 Central Ave., Capitol Hgts. Md.</b>							
23a BURIAL, CREMATION, OR OTHER DISPOSAL <input checked="" type="checkbox"/> Buried <input type="checkbox"/> Cremated <input type="checkbox"/> Other			23b. DATE <b>7/8/68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem</b>			23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>				
24 FUNERAL DIRECTOR <b>Lee Funeral Home</b>						300-4th St. N.E. <b>Wash. D.C.</b>			25a. REC'D BY REGISTRAR DATE <b>JUL 10 1968</b>			25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





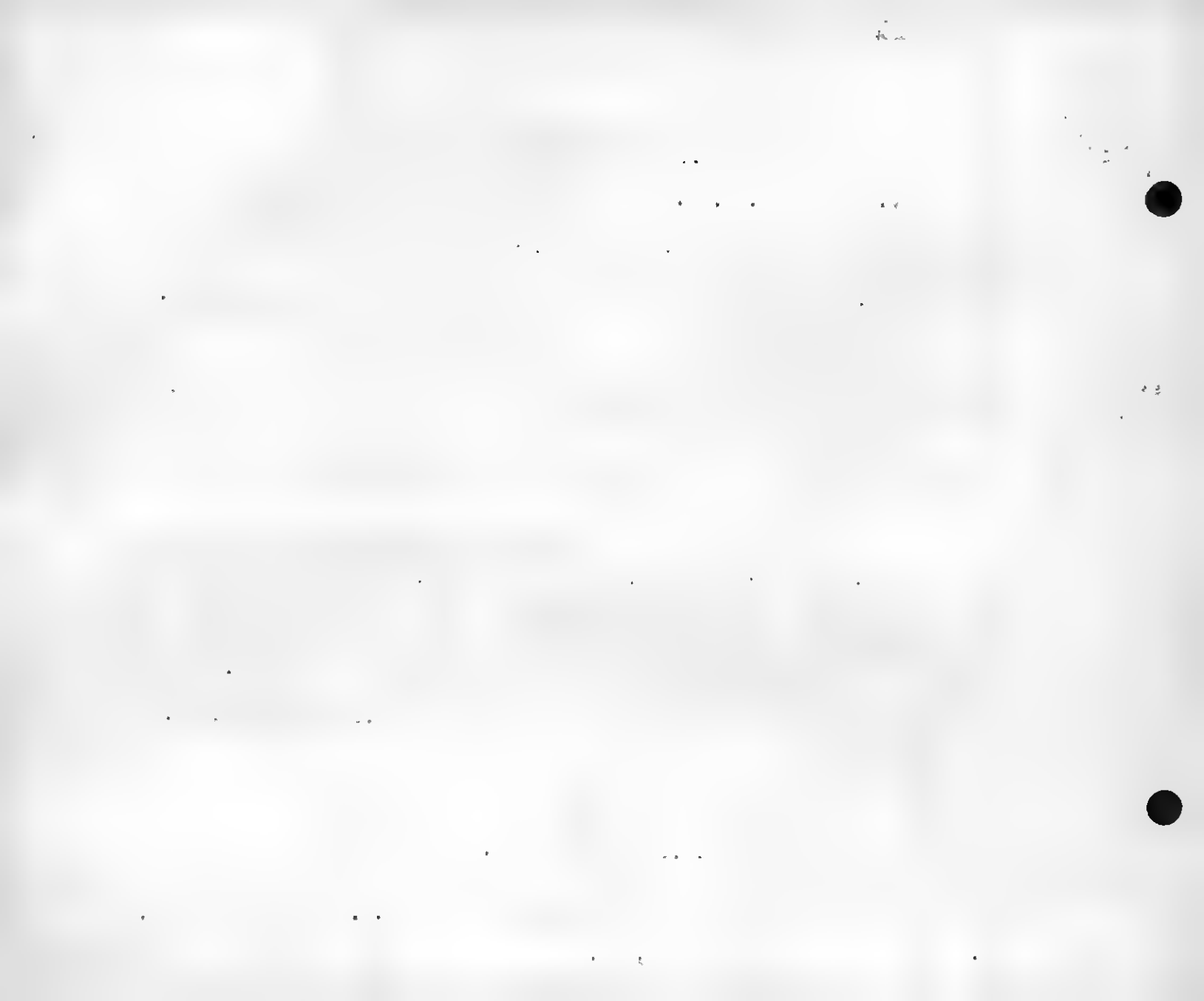
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #8, Film 4404 9/24/68 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b HOUR 11:00 p M		
David			E	Norleen			7 20 1968			11:00 p M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR 12:01 a M	
M	W	26 Mar., 89	79 YRS					7 20 1968		12:01 a M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Minn.		U. S. A.				Prince George Md					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Greenbelt			Greenbelt Nursing Home								
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.			Prince George Beltsville					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4510 Yates Rd.	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Andred Norleen						Matilda ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT			ADDRESS		
No			396 03 6781			Walter A Norleen			Lanham, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4129</u> (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>over 6 months</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Fracture of neck of right femur 30 April 1968</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?					
2 May 1968			Intertochantheric fracture rt femur			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR <u>2:00</u> PM <u>April 30 68</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <u>Fell getting out of car.</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>			21f. LOCATION Street or RFD No City or Town County State <u>4510 Yates Rd., Beltsville, Md.</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
<u>John Kehoe</u>			John Kehoe, M.D., Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			7-21-68		
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			7/24/68		Turlock Memorial Park Camp.			Turlock, Calif.			
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
F. Gasch's Sons Hyattsville, Md.						DATE JUL 25 1968		<u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Inez Mae O'Dowd						Month 7 Day 13 Year 68		4:25 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
female		white		June 3, 1886		82 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U S A				Pr. George's Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince George Hospital		Ret. Saleswoman		Store			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		P. G.		Hyattsville				5600 36th Place	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
James Trail									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			579 03 4465		Paul P. O'Dowd Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>									
4:29 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>5-25</u> , 19 <u>68</u> , to <u>7-13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7-12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
<u>A. Deitz</u>		<u>7-13-68</u>		Aaron Deitz, M. D.		Prince George Plaza Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/16/68		Ft. Lincoln		Colmar Manor P. G. Md.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.				JUL 19 1968		<u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10513

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

10522

1. DECEASED NAME (Type or print) <b>Celso</b>			First Middle Last <b>Paoli</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>68</b>			2b. HOUR M <b></b>		
3 SEX <b>Male</b>			4 RACE <b>White</b>			5 DATE OF BIRTH <b>5-24-96</b>			6 AGE (in years last birthday) <b>72</b> YRS		
7a BIRTHPLACE (State or foreign country) <b>Italy</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Prince George's</b> Md		
10 CITY OR TOWN OF DEATH <b>Silver Hill</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>3804 Aberdeen Street</b>			12a USUA. OCCUPATION (Kind of work done during most of work life, even if retired) <b>Cabinet Maker</b>			12b KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>		
13a USJAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>			13b COUNTY <b>PG</b>			13c CITY OR TOWN <b>Silver Hill</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e STREET AND NUMBER <b>3804 Aberdeen Street</b>			14 FATHER'S NAME First Middle Last <b>Ferdinando Paoli</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Emilia Mazoni</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown			16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>Unknown</b>			17 INFORMANT (Wife) <b>Antoninette Paoli (Same as #13)</b>			Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>meserie gastric (bleeding indary)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of the colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Five years</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Extreme Emaciation</b>											
19a. DATE OF OPERATION <b>1963</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of the colon</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , to <b>1968</b> , that (I) (we) lost saw the deceased alive on <b>July 3rd 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did not) view the body after death.											
22b SIGNATURE <b>John L. Bullock</b> <b>Ramundo P. Plencia</b>						DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS.			22c DATE SIGNED		
22d PHYSICIAN'S NAME (Type)						22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL <b>1</b>			23b. DATE <b>7-20-68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Prince George's Co., Maryland</b>		
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> <b>4308 Suitland Rd. SE, Suitland, Maryland</b>						25a. REC'D BY REGISTRAR <b>JUL 22 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VM-A15ME (5)  
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) First Middle Last <b>GRETA BELLE PAYICH</b>						2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>July 7 1968</b>		2b HOUR <b>2 PM</b>			
3. SEX <b>F</b>		4 RACE <b>W</b>		5. DATE OF BIRTH <b>Dec 19 1924</b>		6 AGE (in years last birthday) <b>39</b> YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	
7a BIRTHPLACE (State or foreign country) <b>Ohio USA</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince Georges</b>		2c DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>1968</b>		2d HOUR <b>4 PM</b>	
10 CITY OR TOWN OF DEATH <b>Cheverly</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges General Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>attendant</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a US-JA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>VA</b>				13b COUNTY <b>Alexandria</b>		13c CITY OR TOWN <b>Alexandria</b>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>6604-8th St</b>	
14 FATHER'S NAME First Middle Last <b>Donald Douglas Ritchie</b>						15 MOTHER'S MAIDEN NAME First Middle Last <b>Evelyn Davis</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>				16b SOCIAL SECURITY NO <b>(If yes give war or dates of service)</b>		17 INFORMANT <b>Hospital Records - Port Palsville</b>				ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>few minutes</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>7-12-68</b>											
19a. DATE OF OPERATION <b>7-12-68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input checked="" type="checkbox"/> <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Subject Stepped off of Pier</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Marina</b>		21f. LOCATION Street or R.F.D. No <input type="checkbox"/> City or Town <input checked="" type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dayton O Watkins</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>7-9-68</b>			
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <b>H. H. Demaine Jr.</b>				ADDRESS				25a. REC'D BY REGISTRAR <b>JUL 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
Rismonda			Petrone			7-23-68		1912:10pm		
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (n years last birthday)	7 UNDER 1 YEAR	7 UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR		
Female	White	7-10-1895	73 YRS	MONTHS	DAYS	Month Day Year		1912:15pm		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Italy		U S A		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work month, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Housewife		None		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland			Prince George's			Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		
Nichola			Casello			Pellegrina		Orlanda		
17. INFORMANT			ADDRESS			17. INFORMANT ADDRESS				
Josephine			Petrone			same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure								minutes		
DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
443x Diabetes mellitus										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
CAUSE OF DEATH			HOUR A.M. P.M.		19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22a. I certify that I took charge of the remains described above, held on death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			7-24-68				
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
Riverdale, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial			7/26/1968		Ft Lincoln Cemetery		Colmar Manor, Maryland			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE	
Valley Funeral Home Mt. Painier, Md.							DATE JUL 29 1968		J Charles Judge	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1505. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2016

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last <b>James D Poindexter</b>				2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 7 26 1968		2b. HOUR a M 8:00 a M	
3 SEX <b>male</b>	4 RACE <b>white</b>	5. DATE OF BIRTH <b>5-22-95</b>	6. AGE (in years last birthday) <b>73</b> YRS	7. UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 7 Day 26 Year 1968	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Hospital</b>		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Capitol Hts.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>209 61st Avenue</b>		14. FATHER'S NAME First Middle Last <b>Unknown</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO <b>579 12 0735</b>		17. INFORMANT ADDRESS <b>Naomi P. Poindexter Same as 13 above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>1129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>430c</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7-27-68</b>	
23a. BURIAL, CREMATION, REMOVAL, SPECIES		23b. DATE <b>7-29-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince George's Co Md</b>	
24. FUNERAL DIRECTOR <b>Robert A. Mattingly</b>		ADDRESS <b>131 11th St S.E. Washington D.C.</b>		25a. REC'D BY REGISTRAR <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

VR A15 (A)  
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
John		J.	Poole	July, 16, 1968		1:00A		
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
M	N		12/12/12		55			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		
S.C.		USA				Prince Georges, Md.		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
Glenn Dale			Glenn Dale Hospital			unknown		unknown
13a USUAL RESIDENCE (Where deceased admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER	
Washington, D.C.					Washington, D.C.			2303 Sherman Ave., N.W.
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME					
John Poole			Mattie Smith					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY		17 INFORMANT			
no			4692 579-05-5992		decedent			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage								10 minutes
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause								
DUE TO, OR AS A CONSEQUENCE OF								
(c) Pulmonary tuberculosis								1 month
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from 7/3/1968, to 7/16/1968, that (X) (we) last saw the deceased alive on 7/16/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death								
22b. SIGNATURE				22c. DATE SIGNED				
Moe Weiss				7/16/68				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
Moe Weiss, M.D.				Glenn Dale Hospital, Glenn Dale, Md.				
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
Burial		7/20/68		Lincoln Memorial Ceme.		Maryland		
24. FUNERAL DIRECTOR				25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Stewart Funeral Home-4001 Benning Rd.				N. JUL 22 1968		Charles Judge		

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print) First Middle Last <b>Leone Irma Pryor</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>7 7 1968</b>		2b. HOUR <b>ab. 11 p. M.</b>	
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>6-20-06</b>	6. AGE (In years last birthday) <b>62</b> YRS.	7. UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <b>7 8 1968</b>		2d. HOUR <b>9:15 a. M.</b>	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>			
10. CITY OR TOWN OF DEATH <b>University Park</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4324 Claggett Road</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>RETIRED TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL SYSTEM</b>	
13a. USUAL RESIDENCE (Where deceased lived, if not in institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>P.G.</b>			13c. CITY OR TOWN <b>University Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>O. B. LLOYD</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ELLA B? LLOYD</b>			13e. STREET AND NUMBER <b>4324 Claggett Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO <b>213-38-1779-A</b>			17. INFORMANT ADDRESS <b>Cabell N. Pryor Husband Same as above</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of head</b> <b>955 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>476 v</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>ab. 11 p. M. 7-7 19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>shot self in head with revolver</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>home</b>		21f. LOCATION Street or R.F.D. No City or Town County State <b>4324 Claggett Road, College Park, P.G., Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Kehoe</b>			EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>7-8-68</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Maryland</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REG. STRAR <b>JUL 11 1968</b>		25b. REG. STRAR'S SIGNATURE <b>J. Charles Judge</b>	





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with n 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
Items & 7a & 7b Film # G4 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print) First Middle Last <b>George W Ransom</b>						2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 7-14-68 199:26pm		2b HOUR		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>8-9-1900</b>	6. AGE (In years last birthday) <b>67</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year <b>7 14 68</b>		2d. HOUR <b>10:04pm</b>		
7a BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md.				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of work no. is even retired) <b>Boiler maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U S Government</b>			
3a USUAL RESIDENCE (Where deceased lived, if not in hospital, residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>		13c CITY OR TOWN <b>Brentwood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>4302 Lawrence Street.</b>	
14. FATHER'S NAME First Middle Last <b>Joseph J Ransom</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Annie Lou Goode</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO <b>577 16 3478</b>		17. INFORMANT ADDRESS <b>Mrs Georgie Ramsom Brentwood, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple skull fractures</b> <b>8120</b> DUE TO, OR AS A CONSEQUENCE OF <b>Trauma - auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>114</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <b>9:25pm 7-14-19 68</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Driver of car involved in collision.</b>						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WH I AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Queen Anne Road and</b>		21f. LOCATION Street or R.F.D. No <b>Route # 214,</b>		City or Town <b>Maryland</b>		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>John Kehoe MD</b>		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <b>7-15-68</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 18, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>				
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>				



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham MD Landover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Geo. Gen. Hosp.</u>				d. STREET ADDRESS <u>3638 Tyrol Dr. Landover Md.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William James Reaves, Sr.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1968</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/1931</u>	9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Photographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>William James Reaves, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Yes</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>579-36-7817</u>		17. INFORMANT <u>Plyce Reaves-Sane AS No. II.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrotic Syndrome</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of the Liver</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/10</u> , 19 <u>68</u> , to <u>7/13</u> , 19 <u>68</u> , that I last saw the deceased alive on <u>7/11</u> , 19 <u>68</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert V. McKnight</u>				ADDRESS (Street, city or town, state) <u>1806 D St NE Wash DC</u> DATE SIGNED <u>7/15/68</u>			
PHYSICIAN'S NAME (Type) <u>Herbert V. McKnight MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u>7-17-68</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony</u>		22d. LOCATION (City, town, or county) (State) <u>Highland Park Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Woolgar</u> ADDRESS <u>45 4925 Dune Ave</u>				DATE <u>JUL 17 1968</u> REGISTERED SIGNATURE <u>Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Margaret</b>					2a. DATE OF DEATH Month <b>7</b> Day <b>24</b> Year <b>68</b>			2b. HOUR <b>12:00</b> M	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>3-9-1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Ireland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Manor - Hagerstown - MD</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>DC</b>		13b. COUNTY <b>Wish DC</b>		13c. CITY OR TOWN <b>Wish DC</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>220 H Street NE-DC</b>	
14. FATHER'S NAME First <b>Patrick</b> Middle <b>Thornhill</b> Last <b>Thornhill</b>		15. MOTHER'S MAIDEN NAME First <b>Julia</b> Middle <b>Mahoney</b> Last <b>Mahoney</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT <b>John M. Dominec - 4902 H St NE - Hagerstown MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure, Congestive</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>yes</b> <b>years</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (a) <b>None</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>5</b> Day <b>1</b> Year <b>1968</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> , 19 <b>66</b> , to <b>7/24</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/18</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John W Winkler MD</b>		22c. PHYSICIAN'S NAME (Type) <b>John W Winkler</b>		22e. ADDRESS <b>5800 10th St Hagerstown MD</b>		22d. DATE SIGNED <b>7/24/68</b>		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET</b>		23d. LOCATION (City or town) (County) (State) <b>WASH D.C.</b>		23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>HANLON FUNERAL HOME. WASH. DC</b>		24a. REC'D BY REGISTRAR <b>JUL 26 1968</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transmission permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Completed by Dr. R. H. M. D. C. W. N. T. R. A. U. B.

10522

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Elsie</b>		First	Middle	Last	2a. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>68</b>		2b. HOUR <b>2:10 P M</b>	
3 SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>8-27-82</b>		6 AGE (In years last birthday) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>		
10. CITY OR TOWN OF DEATH <b>Greenbelt</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greenbelt Com. Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Fauvel</b>		13e. STREET AND NUMBER <b>332 Fauvel Ave.</b>		
14. FATHER'S NAME <b>Eber</b>		First	Middle	Last	15. MOTHER'S M.A.D.E.N. NAME <b>LAURA</b>		First	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>✓</b>		17. INFORMANT <b>Mr Jesse Remington</b>		Address <b>- same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolism</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>cardiac fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>7:00 PM</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral arteriosclerosis</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>7-23-1968</b> to <b>7-29-1968</b> , that (I) (we) lost saw the deceased alive on <b>7-25-1968</b> and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>W. C. WENTRUB</b>				22c. DATE SIGNED <b>7-29-1968</b>		22d. PHYSICIAN'S NAME (Type) <b>W. C. WENTRUB</b>		
23a. BURIAL, CREMATION, REMOVAL <b>REMOVAL</b>		23b. DATE <b>7/27/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUON PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD</b>		
24. FUNERAL DIRECTOR <b>DONALDSON F. H. HUNT</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) First Middle Last ANNA MARGARET RESAU			2a. DATE OF DEATH 7 Month 11 Day 68 Year			2b. HOUR 5:35 AM			
3 SEX Female		4 RACE WHITE		5. DATE OF BIRTH 07/15/98		6. AGE (In years last birthday) 69 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Co. Md.			
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MAGNOLIA CHAPLAIN NURSING HOME 7104 GOOD SUCK		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4053 Edgedale St.	
14. FATHER'S NAME First Middle Last Morris			15. MOTHER'S MAIDEN NAME First Middle Last Mary Morris						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO 214-38-5938		17. INFORMANT Mr. Robt. J. Resau		Address 7002 Emerson St. 20784			
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 6 years. 10 years.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 15, 1968</u> , to <u>Jul 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>9 Jul 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Thomas A. Maloney				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 11 Jul 68			
22d. PHYSICIAN'S NAME (Type) Thomas A. Maloney				22e. ADDRESS 4814 71st Ave. Woodlawn, Hyattsville, Md. 20784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/15/68		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave.				ADDRESS 21229		25a. REC'D BY REGISTRAR JUL 16 1968		25b. REGISTRAR'S SIGNATURE John Charles Judge	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

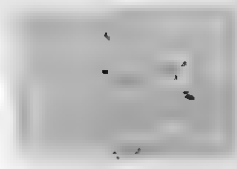
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal; and in any event within 72 hours after death.

10524

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33

1 DECEASED-NAME (Type or Print) First Middle Last <b>Francis Wayne Richards</b>			2a DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 7-29-68 197:50pm			2b HOUR			
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>10-8-1949</b>	6. AGE (In years last birthday) <b>18</b> YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year <b>7 30 68 191:06pm M</b>	2d HOUR
7a BIRTHPLACE (State or foreign country) <b>MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b>			Md
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>			12a USLA OCCUPATION (Kind of work done during most of working life, even if retired) <b>WAS ATTENDANT TEXACO</b>			12b KIND OF BUSINESS OR INDUSTRY
13a USLA RESIDENCE (Where deceased lived, if institution. Residence before 13b CITY OR TOWN <b>Maryland Prince George's Brandywine</b>			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>Rt. 3, Box 274-H</b>			
14 FATHER'S NAME First Middle Last <b>FRANK S. Richards</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ALICE HALL Richards</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>			16b SOCIAL SECURITY NO. <b>213-54-5684</b>			17. INFORMANT <b>FRANK S. Richards</b>			ADDRESS <b>BRANDYWINE, MD</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9278</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>7:45pm 7-29- 19 68</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Drowned while swimming</b>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Nottingham creek at Windsor Landing, Nottingham, Prince Geo. Co., Md.</b>			21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John Kehoe</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <b>7-31-68</b>			
EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
			ADDRESS (Street, city, town, or county)						
23a BURIAL CREMATION REMOVAL (Specify)			23b DATE <b>8-2-68</b>			23c NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>			23d LOCATION (City or Town) (County) (State) <b>Waldorf Charles MD.</b>
24 FUNERAL DIRECTOR <b>WINTT Funeral Home</b>			ADDRESS <b>Waldorf, Md.</b>			25a REC'D BY REG STRAR DATE <b>AUG 5 1968</b>			25b REG STRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10525

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

34

1 DECEASED NAME (Type or print) <b>George Henry Richards</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>8:15AM</b>			
3. SEX <b>Male</b>		4 RACE <b>White Caucasian</b>		5 DATE OF BIRTH <b>Feb. 20, 1892</b>		6 AGE (in years last birthday) <b>76</b> YRS		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's Md</b>			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Prince George's Gen. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tobacco Farming</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Mitchellville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Mill Branch Road</b>	
14. FATHER'S NAME First Middle Last <b>Joseph H. Richards</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret - Goldsmith</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (give war or dates of service) No <input checked="" type="checkbox"/>			
16b. SOCIAL SECURITY NO <b>213-50-9996</b>		17 INFORMANT <b>Katherine R. De Priest-Rd. Bowie, Md.</b>				Address <b>8906 Thompson</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recent Infarction, right basal ganglia &amp; brain stem.</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cerebral arteriosclerosis, marked.</b> (b) DUE TO, OR AS A CONSEQUENCE OF <b>Hypotensive cardiovascular disease.</b> (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4221</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 19, 1968</b> , to <b>July 20, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 20, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <b>DONALD C. EDGREN M.D.</b>		22c. DATE SIGNED <b>7-20-68</b>		22d. PHYSICIAN'S NAME (Type) <b>DONALD C. EDGREN</b>		22e. ADDRESS <b>Hyathtsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baden Pr. Geo Md.</b>			
24. FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 must be retained by the hospital or attending physician, and completely filled out by the general TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro c. LENGTH OF STAY IN IL d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8305 Rosaryville Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS 8305 Rosaryville, Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Le Roy 5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY -		4. DATE OF DEATH July 20 1968 8. DATE OF BIRTH 10-16-52 9. AGE (in years last birthday) 15 yrs. 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LeRoy Roger Richardson Jr. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO 16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME Anna Herriman 17. INFORMANT (Father) LeRoy Roger Richardson, Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 485X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain damage - birth injury.		INTERVAL BETWEEN ONSET AND DEATH 14 hrs 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 1963 to 20 July 1968, that (I) (we) last saw the deceased alive on 20 July 1968, and that death occurred at 9:45 P.M. from the causes and on the date stated above.	
22a. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (Type) [Name]		22b. DATE SIGNED 23d. ADDRESS 24. FUNERAL DIRECTOR'S SIGNATURE Wilhelm Funeral Home, Suitland, Maryland 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE [Signature]	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7-24-68 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION (City, town or county) (State) Suitland, Maryland			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial transit permit. Then please remove chain papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last MARGARET S Ritter		2a. DATE OF DEATH Month Day Year July 19 1968		2b. HOUR MIN 5:30 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 14 Dec 1905	
6. AGE (In years last birthday) 62 YRS		7a. BIRTHPLACE (State or foreign country) VA		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PR. Geo.			
10. CITY OR TOWN OF DEATH COLLEGE PARK		11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 4910 Blackfoot Rd		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife	
12b. KIND OF BUSINESS OR INDUSTRY none		13a. USUAL RESIDENCE (Where deceased lived, if institution, give street address) STATE Md.		13b. COUNTY PR. Geo	
13c. CITY OR TOWN same		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER same	
14. FATHER'S NAME First Middle Last Herman H.F. SCHUTT		15. MOTHER'S M.A.DEN NAME First Middle Last Helen Strutz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO 918-1475E		17. INFORMANT Adeline M. TRUEMAN (sister) 918-1475E Wash DC Phone 417-21	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4120 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive arteriosclerotic Cerebral Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerotic Heart Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> not while <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State 1952 July 68	
22a. I certify that (I) (this hospital) attended the deceased from July 19 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (are not) view the body after death.					
22b. SIGNATURE W.L. Etienne M.D.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7-19-68	
22d. PHYSICIAN'S NAME (Type) W.L. ETIENNE		22e. ADDRESS College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE July 22, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md			
25a. RECEIVED BY REGISTRAR JUL 23 1968		25b. REGISTRAR'S SIGNATURE John J. Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) <b>EDMUND PEARSON ROBINSON</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>JULY 5 1968</b>			2b. HOURS <b>9 PM</b>		
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>July 17 1876</b>	6. AGE (in years last birthday) <b>91 YRS</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>JULY</b> Day <b>5</b> Year <b>1968</b>		2d. HOURS <b>8:15 PM</b>	
7a. BIRTHPLACE (State or foreign country) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <b>Prince Georges General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Prince Georges</b>			13c. CITY OR TOWN <b>Beltsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5512-23 PL</b>	
14. FATHER'S NAME First <b>unknown</b> Middle <b>unknown</b> Last <b>unknown</b>						15. MOTHER'S MAIDEN NAME First <b>PEARSON</b> Middle <b>PEARSON</b> Last <b>PEARSON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO <b>NO</b>			17. INFORMANT <b>Son-in-law Michael Steel Beltsville Md</b>			ADDRESS <b>5512-23 PL</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> DUE TO, OR AS A CONSEQUENCE OF <b>Long standing</b> (b) <b>Arteriosclerotic Heart disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>years</b> (c) <b>Generalized arteriosclerosis</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dayton O Watkins</b>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			7-6-68		
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			531 Sannapolis Rd		
						ADDRESS (Street, city, town, or county)			Beadensburg Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/9/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>						25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		

Two for one Film #Gli02 7/17/68 kk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

10529

10538

1 DECEASED NAME (Type or print) <b>Keith Adrian Robinson</b>			2a DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>1968</b>			2b HOUR <b>5:20</b> <sup>A</sup> <del>M</del>			
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH <b>Feb. 20, 1962</b>		6 AGE (In years lost birthday) <b>6</b> YRS		7 UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md			
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo.Gen'l Hospital</b>		12a USJAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>school</b>		12b KIND OF BUSINESS OR INDUSTRY			
13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Howard</b>		13c CITY OR TOWN <b>Savage</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>Box 132</b>	
14. FATHER'S NAME First Middle Last <b>Adrian C. Robinson</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Betty Jane Sander</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		16b. SOCIAL SECURITY NO.		17 INFORMANT Address <b>Adrian C. Robinson - Above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF <b>intracerebellar hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>vascular malformation of cerebellum</b> (b) (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>37 days</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>none</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>May 26, 1968</b> , to <b>July 3, 1968</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>July 3, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(do not)</del> view the body after death.									
22b. SIGNATURE <b>Ruth K. Jakoby MD</b>				22c. DATE SIGNED <b>8-3-68</b>		22d. PHYSICIAN'S NAME (Type) <b>Ruth K. Jakoby, M. D.</b>			
22e. ADDRESS <b>6401 Landover Rd., Cheverly, Md. 20785</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7-6-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Scaggville Md.</b>			
24. FUNERAL DIRECTOR <b>De Witt Donaldson</b>		ADDRESS <b>Lanham, Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
DATE <b>JUL - 9 1968</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514  
30AM REV. 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <i>Helen Irene Rowe</i>			2a. DATE OF DEATH Month <i>7</i> Day <i>10</i> Year <i>1968</i>			2b. HOUR <i>5:15 AM</i>	
3 SEX <i>- F</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>Apr. 19, 1882</i>		6 AGE (in years last birthday) <i>86</i> YRS	
7a. BIRTHPLACE (State or foreign country) <i>Canada</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George's</i> Md.	
10. CITY OR TOWN OF DEATH <i>Adelphi</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3120 Powder Mill Rd. Takoma Park</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Tailor/ress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>DRESS MAKING</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Prince George's</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>7214 Garland Ave</i>		14. FATHER'S NAME First <i>George</i> Middle <i>-</i> Last <i>Dalmage</i>		15. MOTHER'S MAIDEN NAME First <i>Emme</i> Middle <i>-</i> Last <i>Breckenridge</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>501-71-6330</i>		17 INFORMANT <i>Mrs. Grace Behabetz</i>		Address <i>7214 Garland Ave.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia - left ventricular failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiomyopathy - chronic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i> <i>17 yrs.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>7-2-1</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>11-3</i> , 19 <i>65</i> , to <i>7-10</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>7-3</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R.D. Bauer M.D.</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>7-10-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>R.D. BAUER</i>		22e. ADDRESS <i>2513 Buck Lodge Rd. Adelphi, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>July 12, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Adelphi Prince George's Md.</i>	
24. FUNERAL DIRECTOR <i>Regina</i>		ADDRESS <i>8434 Conner Ave. Silver Spring, Md.</i>		25a. REC'D BY REGISTRAR <i>JUL 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>ABRAHAM</b>		First <b>D.</b> Middle <b>RUCHWARGER</b> Last <b>M.D.</b>		2a DATE OF DEATH Month <b>July</b> Day <b>8</b> Year <b>1968</b>		2b HOUR <b>12 Noon</b>	
3 SEX <b>MALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH <b>SEPT. 1, 1912</b>		6 AGE (In years last birthday) <b>55</b> YRS.	
7a BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md	
10 CITY OR TOWN OF DEATH <b>OXON HILL</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7 MELMARA DRIVE</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MEDICAL</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>P. Georges</b>		13c CITY OR TOWN <b>OXON HILL</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <b>EMANUEL</b> Middle <b>RUCHWARGER</b> Last <b>Unknown</b>		15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>*****</b>		17 INFORMANT Address <b>ZDENKA RUCHWARGER (same as 13e.)</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intense Stenosis of Left Coronary Artery</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>None</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>0 years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 1966</b> to <b>July 6, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 6, 1966</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <b>Herbert Wisotsky</b>		22c. DATE SIGNED <b>7-8-68</b>		22d. PHYSICIAN'S NAME (Type) <b>HERBERT WISOTSKY, M.D.</b>			
22e. ADDRESS <b>101 Audry La., Oxon Hill, Md.</b>							
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>7/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Israel Israel</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Bernard Danzansky & Sons Washington, D.C.							
25a. REC'D BY REGISTRAR <b>JUL 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. J.</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>ANTONIO</b>		First Middle Last <b>RULLO</b>		2a. DATE OF DEATH Month <b>JULY</b> Day <b>6</b> Year <b>1968</b>		2b. HOUR <b>11:30</b> M	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 12, 1880</b>		6 AGE (in years last birthday) <b>88</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>NUSCO, ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>PRINCE GEORGE</b> Md	
10 CITY OR TOWN OF DEATH <b>DISTRICT HEIGHTS</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CASTLEMAN SCHOOL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GOV.</b>	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>DIST. HEIGHTS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>3326 SENATOR AVENUE</b>		14 FATHER'S NAME First <b>ANATO</b> Middle <b>RULLO</b> Last <b>PASTORO</b>		15 MOTHER'S MAIDEN NAME First <b>TERESA</b> Middle <b>PASTORO</b> Last <b>PASTORO</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT <b>E. MICHAEL ROLL</b>		Address <b>3201 LUANA AVE</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 YEARS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>JULY 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>JULY 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <b>BENJAMIN S. PECOEN M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7-6-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>BENJAMIN S. PECOEN M.D.</b>		22e. ADDRESS <b>6106 OLD SILVER HILL ROAD WASH. DC 20028</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7-9-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland PG Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road Suitland Maryland</b>				25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) <b>ETHEL F. RUSSELL</b>					2a. DATE OF DEATH Month <b>JULY</b> Day <b>28</b> Year <b>1968</b>			2b. HOUR <b>10:52</b> AM	
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>2/16/76</b>		6 AGE (in years last birthday) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>GA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PR. GEO.</b>			
10. CITY OR TOWN OF DEATH <b>CLINTON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PINEVIEW GARDEN'S HEALTH CARE</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>Prince George's</b>			13c. CITY OR TOWN <b>CAMP SPRING</b>		13e. STREET AND NUMBER <b>6257 West Chester Dr</b>	
14 FATHER'S NAME First <b>William</b>			15. MOTHER'S MAIDEN NAME First <b>Georgia</b> Middle <b>Williams</b>						
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown)			16b. SOCIAL SECURITY NO. <b>Unknown</b>		17 INFORMANT <b>Frances William</b> Address <b>6257 West Chester CAMP SPRING</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO OR AS A CONSEQUENCE OF <b>ACUTE</b>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF <b>30 YRS</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>NONE</b>									
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify med. cert. examiner)		21b. TIME OF INJURY HOUR A.M. <b>None</b> Month <b>None</b> Year <b>None</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) <b>None</b>					
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <b>None</b>		21f. LOCATION Street or R.D. No. <b>None</b> City or Town <b>None</b> County <b>None</b> State <b>None</b>					
22a. I certify that (this hospital) attended the deceased from <b>5/23, 1962</b> to <b>Present</b> , that (I) <b>(see)</b> last saw the deceased alive on <b>JULY 28, 1968</b> and that in (my) <b>(own)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(see)</b> (did) <b>(did not)</b> view the body after death.									
22b. SIGNATURE <b>Arthur Shaver Jr.</b>					22c. DATE SIGNED <b>JULY 28, 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR.</b>					22e. ADDRESS <b>8808 BRANCH AVE - CLINTON, MD.</b>				
23a. BURIAL, CREMATION <b>Cremation</b>		23b. DATE <b>7-29-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>			
24 FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS <b>4308 Suitland Rd. SE, Suitland, Maryland</b>					25a. RECD BY REGISTRAR <b>AUG 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
304 REV. 1-58

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Agnes -- Salley</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>5:50 P M</b>			
3. SEX <b>Female</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH <b>12/04/1892</b>		6. AGE (In years last birthday) <b>75</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS M N	
7a. BIRTHPLACE (State or foreign country) <b>S. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.			
10. CITY OR TOWN OF DEATH <b>Glenn Dale</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Glenn Dale Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>unknown - retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>			
13a. USJA. RESIDENCE (Where deceased admission) STATE <b>STATE</b>		ved, if institution Residence before 13b. COUNTY <b>13b COUNTY</b>		13c. CITY OR TOWN <b>Wash., D. C.</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>912 Spring Rd., N. W.</b>	
14 FATHER'S NAME First <b>Thomas</b> Middle <b>--</b> Last <b>Evans</b>			15 MOTHER'S MAIDEN NAME First <b>Ida</b> Middle <b>--</b> Last <b>Jenkins</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>unknown</b>		17 INFORMANT <b>Decedent</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201 (b) <b>Hypertensive &amp; arteriosclerotic heart disease</b>								years	
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pleurisy with effusion, left, tuberculous</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. PLACE OF INJURY While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>7/26/</b> , 19 <b>68</b> , to <b>7/30/68</b> , that <del>we</del> (we) last saw the deceased alive on <b>7/30/</b> 1968, and that in <del>the</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) (did not see) view the body after death.									
22b. SIGNATURE <b>Moe Weiss</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>7/30/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>				22e. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>8 - 3-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Suttlund Maryland</b>			
24 FUNERAL DIRECTOR <b>John T. Rhames Co 3015-12th St</b>				25a. REC'D BY REGISTRAR <b>AUG 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Baby Middle Girl Last Sams			2a. DATE OF DEATH July Month 7, Day 1968 Year			2b. HOUR 2:50 P M				
3 SEX Female			4. RACE Caucasian			5. DATE OF BIRTH July 7, 1968			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS 5 14		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo.Gen'l Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY None				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Mt. Rainier			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 412 36th St.	
14. FATHER'S NAME George Sams			15. MOTHER'S MAIDEN NAME Wanda G. Graham										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. None			17 INFORMANT Prince George's Hospital Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY.													
IMMEDIATE CAUSE (a) <u>7761</u> <u>Atelantasi</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Distress Syndrome</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>7623</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from <u>7/7</u> , 19 <u>68</u> , to <u>7/7</u> , 19 <u>68</u> , that (we) last saw the deceased alive on <u>7/7</u> , 19 <u>68</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>John W. Perkins</u>						DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>7/8/68</u>				
22d. PHYSICIAN'S NAME (Type) John W. Perkins, M. D.						22e. ADDRESS Prince Geo. General Hospital, Cheverly, Maryland							
23a. BURIAL (CREMATION, REMOVAL SPECIFY) Burial			23b. DATE 7-11-1968			23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			23d. LOCATION (City or Town) (County) (State) Washington, D.C. Maryland				
24. FUNERAL DIRECTOR Valley Funeral Home Mt. Rainier, Md.						25a. REC'D BY REGISTRAR DATE JUL 12 1968			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First <b>John</b>	Middle <b>E.</b>	Last <b>Schaeffer</b>	2a. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>1:40PM</b>
3. SEX <b>male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>1/31/16</b>		6. AGE (In years lost birthday) <b>52</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	8. IF UNDER 24 HRS HOURS <b></b> MIN <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Pa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>			Md
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Gen. Hosp.</b>		12a. LSLA. OCCUPATION (Kind of work done during most of work life, even if retired) <b>Federal Comm. Officer</b>		12b. K.IND OF BUSINESS OR INDUSTRY <b>U. S. Gov't</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Greenbelt</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>61 Ridge Road</b>	
14. FATHER'S NAME First <b>Wilson</b> Middle <b>Schaeffer</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>Alice</b> Middle <b>Kuhns</b> Last <b></b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <b>-----</b>		17. INFORMANT Address <b>Hospital Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hepatic failure</b> <b>5/10</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>Nutritional Carcinosis of Liver</b> (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF <b>alcohol (?)</b> (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Fibrinous pericarditis</b>									
19a. DATE OF OPERATION <b>15 July 68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Saundice</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No <b></b> City or Town <b></b> County <b></b> State <b></b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/1/68</b> to <b>7/20/68</b> , that (I) (we) saw the deceased alive on <b>July 20, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John H. Bayly M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <b>John H. Bayly</b>		22e. ADDRESS <b>Washington D C</b>		22c. DATE SIGNED <b>July 20, 1968</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jordan Lutheran Church</b>		23d. LOCATION (City or Town) (County) (State) <b>Walberts Lehigh Penna.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When placed in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Mary Catherine Schwartz						Month Day Year			6 05 PM
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	12-22-1882			85 YRS.		MONTHS DAYS		HOURS MIN.
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ohio		U.S.A.				Prince George Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Lanham			Magnolia Gardens N.H.			Ret Saleswoman			Rept Store
13a USUAL RESIDENCE (Where deceased admission)			13b. COUNTY		13c CITY OR TOWN		13d INS DE CITY LIM TS?		13e STREET AND NUMBER
Maryland			Prince George		Landover Hill		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4210-72nd Ave.
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
John Suedkamp			Mary Koch						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT		Address		
No			382-05-7933		Louis H. Schwartz		Same as # 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Rt. femoral thrombosis									2 w.
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									Years
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Osteoarthritis. Rt. hemiplegia with aphasia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year							
		P.M. 19							
21d INJURY OCCURRED		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION				
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from July 19, 1967, to July 14, 1968, that (I) (we) lost saw the deceased alive on July 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE			22c. DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e DATE SIGNED	
Harry Sachs, M.D.								7/14/68	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Harry Sachs, M.D.			3036 M Place, S.E. Wash. D.C.						
23a B. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Buried		7/17/68		Ft. Lincoln		Colmar Manor P.G. Md.			
24 FUNERAL DIRECTOR					ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE
Francis Gasch's Sons Hyattsville, Md.							JUL 17 1968		Charles Judge



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form X-773. Page 5 may be retained for your files.

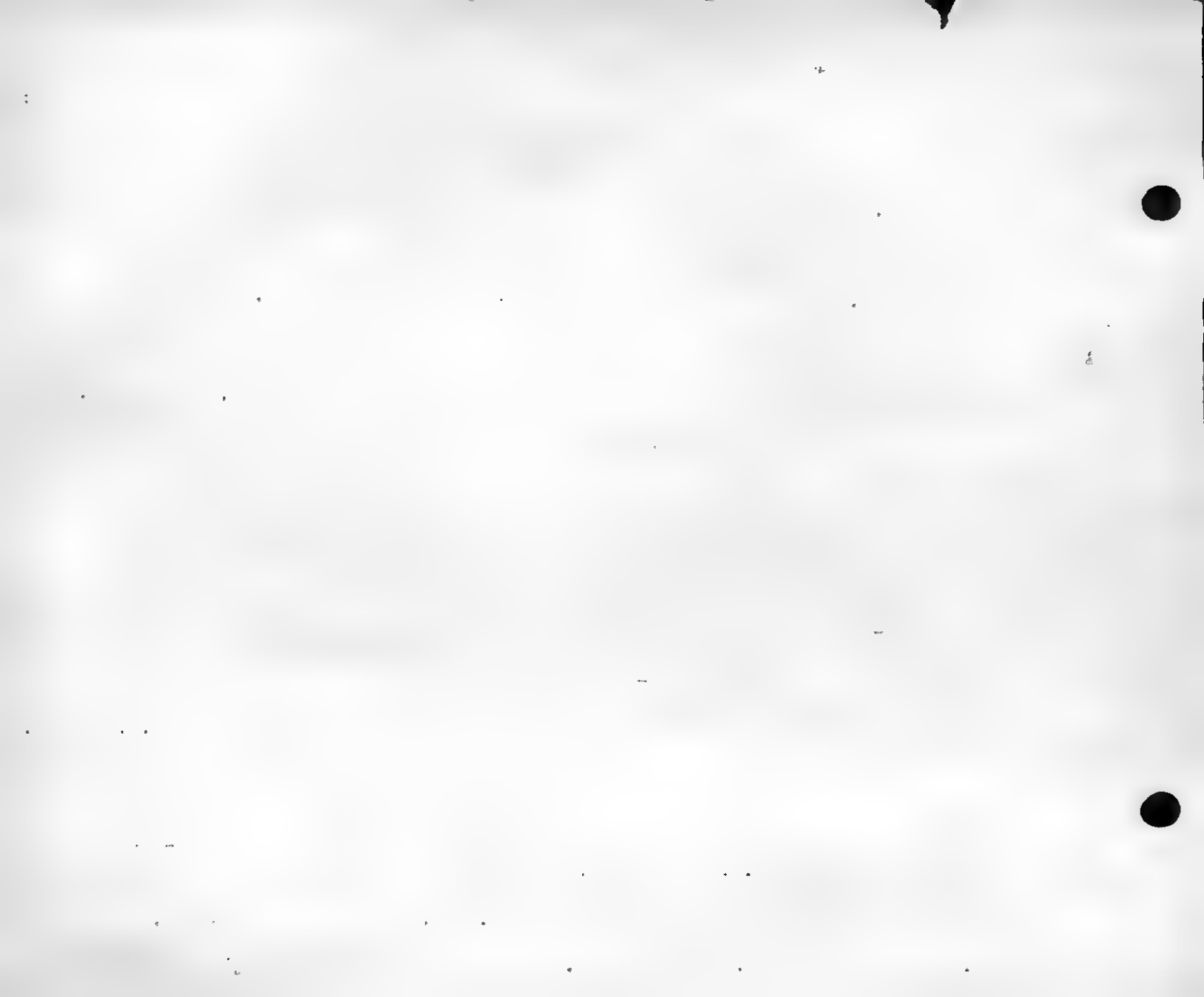
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 21c film 403  
8-5-68 mt

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last <b>Louis Simmons</b>			2a DATE KNOWN OF DEATH EST. <input checked="" type="checkbox"/> Month Day Year <b>7 26 1968</b>		2b HOUR a M <b>10:06</b>
3 SEX <b>male</b>	4 RACE <b>Negro</b>	5 DATE OF BIRTH <b>4-14-32</b>	6 AGE (In years last birthday) <b>36</b> WS	IF UNDER 1 YEAR MONTHS DAYS <b>7 26</b>	IF UNDER 24 HRS HOURS MIN <b>10 06</b>
7a BIRTHPLACE (State or foreign country) <b>Va.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince George's</b> Md	
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL, OR INSTITUTION (if not in hospital give street address) <b>Prince George's Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>Baltimore</b>	13c CITY OR TOWN <b>Baltimore</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>2129 North Street</b>
14 FATHER'S NAME First Middle Last <b>Johnnie Moore Simmons</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Fannie Mae Garrett</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO <b>227 36 8529</b>		17 INFORMANT ADDRESS <b>Suzanne Simmons 1805 N. Mount St.</b>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intra-cerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>fell off</b>					
19a DATE OF OPERATION <b>7-11-68</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intra-cerebral hemorrhage</b>		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <b>11:00 P.M. 7-9 1968</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>fell off truck</b>	
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>8000 blk Montpelier Dr.</b>		21f LOCATION Street or RFD No City or Town County State <b>Bowie, P.G. Md.</b>	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <b>7-27-68</b>	
EXAMINER'S NAME (Type) <b>John Kehoe M.D., Riverdale, Maryland</b> ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b DATE <b>7/30/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Pk.</b>	
24 FUNERAL DIRECTOR <b>Kelson Fun'l Home</b>		25a REC'D BY REGISTRAR <b>JUL 29 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	
V.R. Bailly 1348 N. Calhoun St.					





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 22a Film 404  
9-24-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10581

1. DECEASED-NAME (Type or Print) First Middle Last <b>Marsha Louise Skeens</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>7 30-68 1972</b>			2b. HOUR <b>20pm</b>		
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>2-12-1944</b>	6 AGE (In years last birthday) <b>24</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year <b>7 30 68 1972</b>			2d. HOUR <b>20pm</b>		
7a. BIRTHPLACE (State or foreign country) <b>Washington D C</b>		7b. C.T. ZONE OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md					
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Landover</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		3e. STREET AND NUMBER <b>5119 Flintridge Drive</b>	
14. FATHER'S NAME First Middle Last <b>Salvatore Turrisi</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Esther Parsons</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16b. SOCIAL SECURITY NO (If yes give year or dates of service)		17. INFORMANT ADDRESS <b>James T Skeens Landover, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of abdomen</b> <b>985x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>9170</b>											
19a. DATE OF OPERATION <b>7-30-68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>6:37pm 7-30- 19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>5309 Riverdale Road, Riverdale, Prince George County, Maryland</b>		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <b>John Kehoe</b>		EXAMINER'S NAME (Type) <b>John Kehoe MD</b>		RIVERDALE, MARYLAND		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug 3, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Colmar Manor</b>		(County) <b>Pro Geo</b>		(State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 11 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10540

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) -			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Clifton			R.		Smith	7 Month 31 Day 68 Year			6:15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		5-4-03		65 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Prince George Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Eugene Leland Memorial			Retired			W S S C		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIM 157		13e. STREET AND NUMBER			
Maryland			Prince George		Hyattsville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5306 Kenilworth Ave.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	
Edward					Smith	Goldie				McCauley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
						Spouse and Medical Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ruptured abdominal aortic aneurysm</u> <u>441. X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>451 X</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>31 JULY</u> , 19 <u>68</u> , to <u>31 JULY</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>31 JULY</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>DR. KENOE NOTIFIED</u>											
22b. SIGNATURE <u>C. J. Houmann</u>					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8-1-68		
22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M.D.					22e. ADDRESS 4408 Queensbury Rd., Riverdale, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial		Aug 3, 1968		Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons					Hyattsville Md.		DATE AUG 5 1968		<u>J. Charles Judge</u>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
10M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) First Middle Last <b>FRANK VINCENT SMITH</b>						2a. DATE KNOWN OF EST. DEATH <input checked="" type="checkbox"/> Month Day Year <b>July 6 1968</b>		2b. HOUR <b>1:05 PM</b>		2c. DATE PRONOUNCED DEAD <input type="checkbox"/> Month Day Year <b>July 6 1968</b>	
3 SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>Sept 23 1936</b>	6. AGE (in years last birthday) <b>32 YRS</b>	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	8. UNDER 24 HRS MONTHS DAYS HOURS MIN	9. COUNTY OF DEATH <b>Prince Georges</b>		10. CITY OR TOWN OF DEATH <b>Chesley</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <b>Prince Georges</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>		10. CITY OR TOWN OF DEATH <b>Chesley</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <b>Prince Georges</b>	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter Construction</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Chesley</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Joseph P Smith</b>		15. MOTHER'S M A D E N NAME First Middle Last <b>Edna M Alvey</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT <b>CAROL A Smith Lane #13</b>		17. ADDRESS	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Toxemia + Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Hemorrhagic Pancreatitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 day</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5811</b>											
19a. DATE OF OPERATION <b>5811</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dayton O Watkins</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 7-6-68		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>5315</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county) <b>Beltsburg, Md</b>	
EXAMINER'S NAME (Type) <b>DAYTON O. WATKINS</b>		23a. BURLIA, CREMATION REMOVAL (Specify) <b>July 9, 68</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR <b>Brook Bros</b>	
24. FUNERAL DIRECTOR <b>Brook Bros</b>		ADDRESS <b>101-103 W. York St. Baltimore, Md</b>		25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>GRACE V. SMITH</b>			2a. DATE OF DEATH Month <b>JULY</b> Day <b>7</b> Year <b>1968</b>		2b. HOUR <b>12:55 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAU.</b>	5. DATE OF BIRTH <b>AUGUST 21, 1885</b>		6. AGE (In years last birthday) <b>82</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>PRINCE GEORGE</b>		
10. CITY OR TOWN OF DEATH <b>LANHAM</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MAGNOLIA GARDENS REST HOME</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>REG. NURSE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MED.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>PRINCE GEORGE</b>	13c. CITY OR TOWN <b>HYATTSVILLE</b>	13d. INSIDE CITY, TOWN? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>3603 GALLATIN STREET</b>	
14. FATHER'S NAME First <b>JOHN</b> Middle <b>W.</b> Last <b>SMITH</b>	15. MOTHER'S MAIDEN NAME First <b>JAQUELINE</b> Middle <b>HINKINS</b> Last <b>HINKINS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		
16b. SOCIAL SECURITY NO <b>578-01-5627</b>		17. INFORMANT <b>RICHARD M. SMITH Nephew</b>		Address <b>7419 Farmcrest Dr New Carrollton, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY <b>4101</b> IMMEDIATE CAUSE (a) <b>acute coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (d) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>chronic obstructive lung disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1968</b> to <b>July 7, 1968</b> that (I) (we) lost saw the deceased alive on <b>June 22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death					
22b. SIGNATURE <b>Don B. Cameron</b>		DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) <b>DON B. CAMERON</b>		22e. ADDRESS <b>3503 PERRY ST MT. RAINIER, MD</b>		22c. DATE SIGNED <b>7-7-68</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/10/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Marian</b>		First <b>MARIAN</b>	Middle <b>M.</b>	Last <b>Smith</b>	2a DATE OF DEATH Month <b>7</b> Day <b>5</b> Year <b>68</b>		2b HOUR <b>330 P M</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>7-9-97</b>		6 AGE (In years lost birthday) <b>70</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>
7a BIRTHPLACE (State or foreign country) <b>Harrisburg, Va.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince Georges</b> Md			
10 CITY OR TOWN OF DEATH <b>Clinton</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Clinton Community Hosp.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>D.C.</b>		13b COUNTY <b>Washington</b>	13c CITY OR TOWN <b>Washington</b>	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER <b>5510 4th Street N. W.</b>		
14. FATHER'S NAME First <b>George</b> Middle <b>E.</b> Last <b>Shreve</b>		15. MOTHER'S MAIDEN NAME First <b>Sullivan</b> Middle <b>Sullivan</b> Last <b>Sullivan</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address <b>Augustus G. Smith, Jr. 5510 4th St N.W. Wash</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>UNK</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>4201</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 Days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Congestive Heart Failure, Deep vein Thrombosis</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>—</b>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/24/68</b> 19 <b>68</b> , to <b>7/5/68</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/5/68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Robert W. Merkle, M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7/5/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Robert W. Merkle, M.D.</b>				22e. ADDRESS <b>116 McKendree Rd, Brandywine, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>7-9-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Clinton P G Maryland</b>	
24 FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road Suitland Maryland</b>				25a. REC'D BY REGISTRAR <b>JUL 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100-100

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
Mary Agnes Sprouse						July 13 1968		M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White				76 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
U.S.A.		U.S.A.				Prince George County		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Forestville			Regent Nursing Home			Retired				
13a. USUAL RESIDENCE (Where deceased lived, if not then on, Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Montgomery		Hartsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		7402 Jefferson St.	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If you give year or dates of service)		17. INFORMANT		Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>									Summed	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic carcinoma</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced Ca Breast</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Advanced leukemia due to chronic lymphocytic</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/15/68</u> to <u>7/13/68</u> , that (I) (we) last saw the deceased alive on <u>7/12/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Kelvin L. Minchin M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>7/13/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>KELVIN L. MINCHIN</u>					22e. ADDRESS <u>6400 MARLBOROUGH PIKE SE</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>7-17-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL</u>		23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>				
24. FUNERAL DIRECTOR <u>W W Chambers</u>				ADDRESS <u>1400 Chapin St NW</u>		25a. REC'D BY REGISTRAR <u>JUL 17 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 404 Maryland State Department of Health  
9-25-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR			
Robert			C			Stanwood			7-27-68			19 ? M			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F. UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR				
Male	White	12-27-1921	46 YRS					7 30 68			197:03pm M				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH									
Illinois		USA				Prince George's Md									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY						
Cheverly			Prince George Hospital			Manager			Retail Store						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Maryland				Prince George's		Oxon Hill		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2900 St. Clair Drive, #422					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Robert C. Stanwood				Bea Roth											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOC. A. SECURITY NO.		17. INFORMANT (Brother) 3122 ADDRESS Panorama Road									
YES				1942-46		Hubert C. Stanwood, Riverside, California									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:												Minutes			
IMMEDIATE CAUSE (a) Heart failure															
DUE TO, OR AS A CONSEQUENCE OF															
(b) Hypertensive cardiovascular disease												Unknown			
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
4120															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)									
CAUSE OF DEATH			HOUR A.M. P.M.			19									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town			County		State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
John Kehoe MD			Riverdale, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			7-31-68			
									DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County) (State)				
Cremation			8-2-68		Cedar Hill Cemetery			Suitland, Maryland							
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Wilhelm Funeral Home						4308 Suitland Rd. SE, Suitland, Maryland			DATE AUG 8 1968		Charles Judge				



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit receipt. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10560 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item#11, 15, 16b, Film#1188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		<input type="checkbox"/> EST	Month	Day	Year	2b. HOUR
Eli								7-19-68		<input checked="" type="checkbox"/>	7	19	68	30pm
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR MONTHS DAYS		+ F UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR		
Male	Negro	8-18-1888		79 YRS						Month Day Year		7 19 68 6:05pm		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Va.		U.S.A.				Prince George's								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY								
Cheverly		Prince George Hospital												
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER						
Maryland		Prince George's		Fairmount Heights				1019 58th. Avenue						
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last												
Spencer Stokes		Lancy Ginny Hall												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS										
MC		8-18-1983		Dorothy Lynn 1019-58th Avenue										
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4:00 PM DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4:00 PM														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS(Street, city, town or county)		22b. DATE SIGNED		
		John Kehoe, MD, Riverdale, Md.						<input checked="" type="checkbox"/>				7-20-68		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)								
Burial		7-27-68		Harmony		Landover, Maryland								
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
J. W. R. L. Home, Inc.		4339 Hunt Pl Washington, DC		DATE JUL 26 1968										



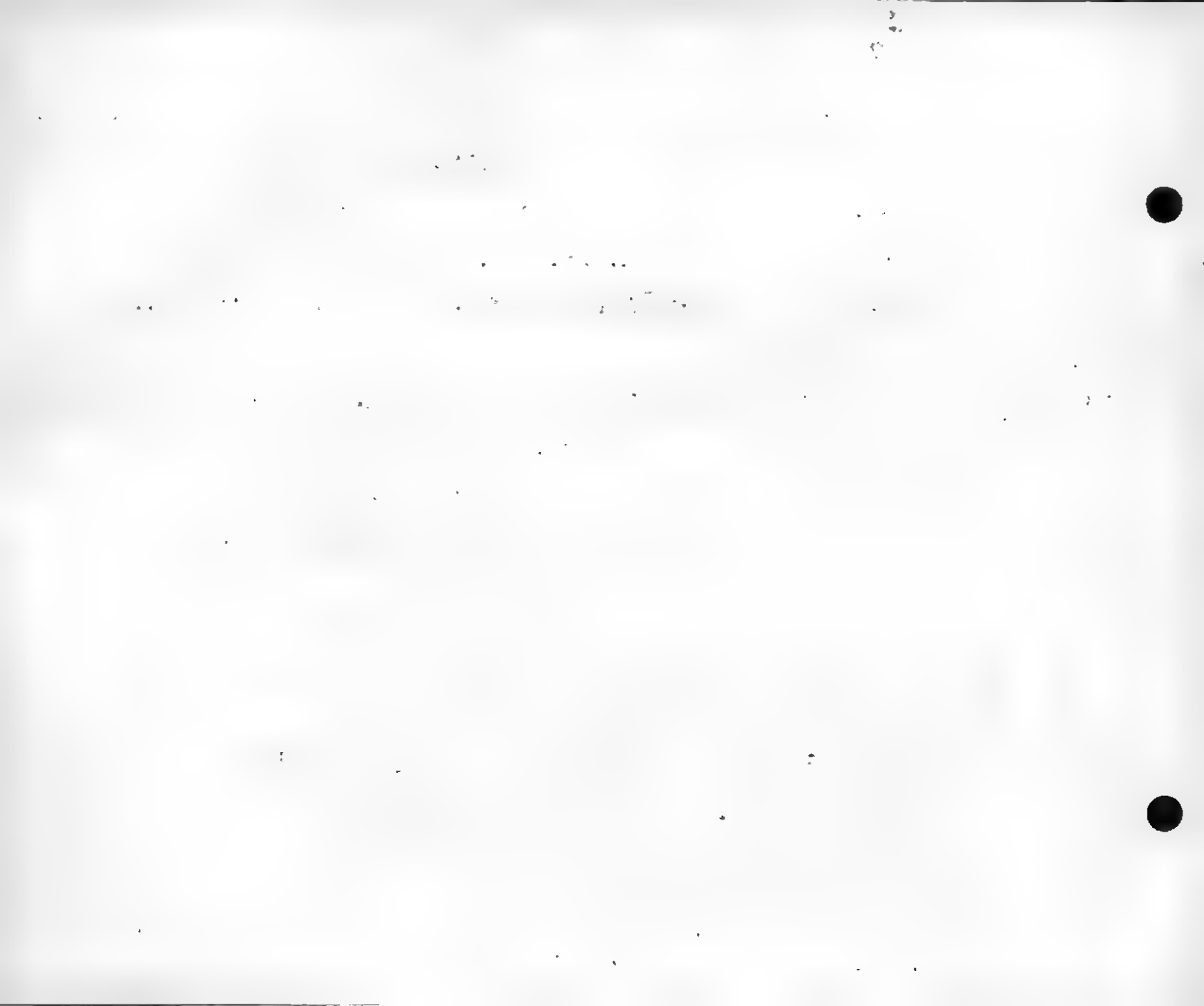


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>Isaac</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>8:20A</b> M								
3. SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>12/14/78</b>		6. AGE (In years last birthday) <b>89</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>				
7a. BIRTHPLACE (State or foreign country) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.								
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Superintendent</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>			13c. CITY OR TOWN <b>Silver Spr.</b>			13d. INSIDE CITY - APTS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>921 Northwest Dr.</b>		
14. FATHER'S NAME First <b></b> Middle <b></b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b></b> Middle <b></b> Last <b></b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <b>218-32-9696</b>		17. INFORMANT Address <b>M. Leon Strauss 7905 Roston Ave</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b> <b>410.1</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary atherosclerosis</b> Approximate interval between onset and death: <b>7/19/68</b> <b>?</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>1968</b> P.M. <b></b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. <b>719 68</b>			City or Town <b></b> County <b></b> State <b></b>					
22a. I certify that (I) <b>(the hospital)</b> attended the deceased from <b>7/19</b> , 19 <b>68</b> , to <b>July 22</b> , 19 <b>68</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>7/21</b> , 19 <b>68</b> , and that in (my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did) (did not) view the body after death.														
22b. SIGNATURE <b>Bernard J. Walsh, M.D.</b> DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>7/22/68</b>								
22d. PHYSICIAN'S NAME (Type) <b>BERNARD J. WALSH, MD</b>						22e. ADDRESS <b>1800 Cypress St. N. DC</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/23/1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Sharon Chapel</b>			23d. LOCATION (City or Town) (County) (State) <b>Balta Md</b>					
24. FUNERAL DIRECTOR <b>Sylvan S. Lerner &amp; Son, INC</b>						25a. REC'D BY REGISTRAR <b>JUL 24 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																																							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																																							
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR																						
Louis			L.		Strickler				<input checked="" type="checkbox"/> 7		9		1968		10:00		p M																						
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year																					
male		white		10-1-28		39 YRS		MONTHS		DAYS		7		9		1968		10:00																					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 COUNTY OF DEATH																														
Virginia			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Prince George's									Md																					
1d CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY																											
Riverdale				Leland Memorial Hospital				Carpenter				Building																											
13a USUAL RESIDENCE (Where deceased lived, if institution Res. den. before admission) STATE				13b COUNTY				13c CITY OR TOWN				13d INSIDE CITY LIMITS?				13e STREET AND NUMBER																							
Md.				P.G.				Riverdale				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				5810 Cleveland Avenue																							
4 FATHER'S NAME					First					Middle					Last					15 MOTHER'S MAIDEN NAME					First					Middle					Last				
EDWARD S. STRICKLER																				MARGARET GOOD																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16b SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS																								
No					None					Unknown					Connie M. Strickler					5810 Cleveland Ave. Riverdale, Md.																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracerebral and Subarachnoid Hemorrhage</u>																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																																							
(b) <u>7-11-68</u>																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
19a DATE OF OPERATION																		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																			
																				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1B)																															
CAUSE OF DEATH				19																																			
21d INJURY OCCURRED				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town				County				State																			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>																																							
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE				EXAMINER'S NAME (Type)				John Kehoe M.D., Riverdale, Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED				7-11-68											
23a BURIAL CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town)				(County)				(State)																			
Burial				July 13, 1968				Fort Lincoln Cemetery				Bladensburg, Maryland																											
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE																											
W. W. CHAMBERS CO.				Riverdale, Md.				JUL 15 1968				Charles Judge																											



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 15-1  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) <b>George</b>			First <b>C.</b> Middle <b>Sullivan</b> Last			2a DATE OF DEATH Month <b>7</b> Day <b>28</b> Year <b>68</b>		2b HOUR <b>1:45</b> a.m.		
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>10/11/01</b>		6 AGE (In years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince Georges</b>				
10 CITY OR TOWN OF DEATH <b>Riverdale</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>Retired</b>		12b KIND OF BUSINESS OR INDUSTRY <b>farmer</b>		
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Md.</b>			13b. COUNTY <b>Prince Georges</b>		13c CITY OR TOWN <b>Beltsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>P.O. Box 61</b>	
14 FATHER'S NAME First <b>Robert</b> Middle <b>Sullivan</b> Last			15. MOTHER'S MAIDEN NAME First <b>Mamie</b> Middle <b>R</b> Last <b>iseley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>213 32 4549</b>		17 INFORMANT <b>Edna Sullivan</b>		Address <b>Beltsville, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal Failure &amp; Systemic</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hepatic Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis of Liver</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b> <b>1 yr</b> <b>3 yrs.</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>5810</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>7/4/68</b> , 19 <b>68</b> , to <b>7/28</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7-27-68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes noted above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>W.L. Etienne</b>		DEGREE <b>U.L. ETIENNE</b>		ATTENDING PHYS. <b>College Park, Md</b>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>7-28-68</b>		
22d. PHYSICIAN'S NAME (Type)		23a. B. RIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 31, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyattsville Pro Geo Md</b>		
24 FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville Md</b>				25a. REC'D BY REGISTRAR <b>AUG 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

13550

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

59

1. DECEASED-NAME (Type or print) <b>THOMAS I. SWANN</b>			2a. DATE OF DEATH <b>7<sup>th</sup> Month 19<sup>th</sup> Day 1968</b>		2b. HOUR <b>11:50 M</b>
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>3/16/1887</b>		6. AGE (In years last birthday) <b>81 YRS</b>	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. BIRTHPLACE (State or foreign country) <b>MD.</b>			9. COUNTY OF DEATH <b>PRINCE GEORGES Md</b>		
10. CITY OR TOWN OF DEATH <b>CLINTON</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>CLINTON COMMUNITY HOSP</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CONDUCTOR - RAILROAD</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>PR. GEO. BRANDYWINE</b>		13c. CITY OR TOWN <b>RT 2 BOX 280</b>	
14. FATHER'S NAME <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-07-8109</b>		17. INFORMANT <b>EDITH R. SWANN BRANDYWINE, MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>TERMINAL BRONCHOPNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBROVASCULAR ACCIDENT - ARTERIO-SCLEROTIC CV DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>8 DAYS</b> <b>11 DAYS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>NONE</b>					
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NONE</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (If either, not a medical examiner) <b>NONE</b>		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>NONE</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>NONE</b>	
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <b>NONE</b>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <b>NONE</b>		21f. LOCATION Street or R.F.D. No City or Town County State <b>NONE</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH, 1966</b> to <b>PRESENT</b> , that (I) (we) last saw the deceased alive on <b>JULY 19, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Arthur Shaver Jr M.D.</b>				22c. DATE SIGNED <b>7/20/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. M.D.</b>				22e. ADDRESS <b>8808 BRANCH AVE. - CLINTON, MD.</b>	
23a. BYRIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7-23-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>	
24. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME WADSWORTH, MD</b>		23d. LOCATION (City or Town) (County) (State) <b>CLINTON PR GEO. MD</b>		23e. REC'D BY REGISTRAR <b>JUL 24 1968</b>	
23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VP 415ME (3-64)  
104 REV 1/64

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print) First Middle Last <b>Clarence Theodore Sword</b>						2a. DATE KNOWN OF DEATH Month Day Year <b>7-10-68</b>		2b. HOUR <b>PM</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>8-7-1900</b>	6 AGE (In years last birthday) <b>67</b> YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <b>7 19 68</b>		2d. HOUR <b>10:30pm</b>		
7a. BIRTHPLACE (State or foreign) <b>Washington D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>				
10. CITY OR TOWN OF DEATH <b>Brentwood</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>3706 Windom Road</b>			2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Printer</b>		12b. USUAL BUSINESS OR INDUSTRY <b>Government</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince George's</b>			13c. CITY OR TOWN <b>Brentwood</b>		13d. INSIDE CITY, JAN 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Edward Sword</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Gussie Cowan</b>			13e. STREET AND NUMBER <b>3706 Windom Road</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b. SOCIAL SECURITY NO <b>WW 11</b>		17. INFORMANT ADDRESS <b>George E. Sword North Beach Park, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>41-47</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>John Kehoe</b>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>7-14-68</b>		
EXAMINER'S NAME (Type) <b>John Kehoe MD</b>			<b>Riverdale, Md.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS <b>George Washington</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Hyattsville</b>			23d. LOCATION (City or Town) (County) (State) <b>P. G. Md.</b>		23e. REG. BY REG. STRAR <b>Francis Gasch's Sons</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hyattsville</b>		23d. LOCATION (City or Town) (County) (State) <b>P. G. Md.</b>		23e. REG. BY REG. STRAR <b>Francis Gasch's Sons</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>			ADDRESS <b>Hyattsville, Maryland</b>			25a. REC'D BY REG. STRAR <b>DATE</b>		25b. REG. STRAR'S SIGNATURE <b>Charles Judge</b>		



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item a, b, Film GL 03 8 / MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) <b>Marlin E Tate</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7-24-68 192:15am M			2b. HOUR		
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>21 Oct. 1936</b>	6 AGE (in years last birthday) <b>31 YRS</b>	7 UNDER YEAR MONTHS <b>7</b> DAYS <b>24</b>	IF UNDER 24 HRS HOURS <b>19</b> MIN <b>15</b>	2c. DATE PRONOUNCED DEAD Month <b>7</b> Day <b>24</b> Year <b>1968</b>			2d. HOUR <b>2:30am M</b>		
7a. BIRTHPLACE (State or foreign country) <b>Wash., D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>S</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's Md</b>					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Prince George Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Bookkeeper</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, institution or residence before admission) STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Prince George's Mt. Rainier</b>			13c. IS-OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>3210 Upshur Street</b>		
14. FATHER'S NAME First Middle Last <b>Henry Lee Leister Arnold Arnold</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary E Larrick Violet Lueve Larrick</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO (If yes give year or dates of service)		17. INFORMANT <b>Violet L Arnold</b>			ADDRESS <b>Mt Rainier, Md.</b>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF <b>Glomerulosclerosis</b> (b) <b>From Diabetic nephropathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>over 1 yr.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John Kehoe MD</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>			22b. DATE SIGNED <b>7-24-68</b>			ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>July 27, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) <b>Colmar Manor Pro Geo Md.</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Md.</b>			25a. RECD BY REGISTRAR DATE <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items #7a,b,&23a,b,c,d. Film 4027									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Herbert C Tegeder						July 3 1968		3,45A	
3 SEX		4 RACE		5 DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		9 Mar., 1887		81 YRS.			
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Balto., Md.		USA				Pr. Geo. Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Pr. Geo., Gen. Hosp.,							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Pr. Geo.		Maryland Park				100 64th Place	
14. FATHER'S NAME First Middle Last			15. MOTHER'S M.A.DEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Broncho-pneumonia, bilateral, lower lobes.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stenosing coronary arteriosclerosis with old occlusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>of the anterior descending branch of the left</u> (c) <u>coronary artery with old antero-septal infarct.</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Generalized arteriosclerosis, severe.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>March 9, 1968</u> , to <u>July 3, 1968</u> , that (I) <u>(we)</u> saw the deceased alive on <u>July 3, 1968</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> (did) <u>(do not)</u> view the body after death.									
22b. SIGNATURE <u>Peter Duus M.D.</u>				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
						22e. ADDRESS			
						6056 Central Ave., Capitol Hgts, Md. 20027			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		July 6, 1968		Columbia Gardens Cemeter.		Arlington, Virginia			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REG STRAR DATE		25b. REGISTRAR'S SIGNATURE			
Ives Funeral Home Arlington 1, Va.				JUL - 8 1968		<u>Charles J. J...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
10554																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First <b>Kathryn</b>			Middle <b>M.</b>			Last <b>Thomas</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>7:54</b> M		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>March 7, 1912</b>			6. AGE (In years last birthday) <b>56</b> YRS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Penn.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b> Md.								
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House wife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>								
13a. USUA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Prince Georges</b>			13c. CITY OR TOWN <b>Adelphi</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>9234 Riggs Rd.</b>					
14. FATHER'S NAME First <b>James</b> Middle <b>Mineweaser</b>						15. MOTHER'S MAIDEN NAME First <b>Kathrine</b> Middle <b>O'Farrell</b> Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>no</b> unknown			16b. SOCIAL SECURITY NO. <b>215-20-3561</b>			17. INFORMANT <b>Daniel Thomas</b>			Address <b>9234 Riggs Rd. Adelphi, Md</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Valvular Stenosis &amp; Aortic Regurgitation</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>June 2, 1968</b> to <b>July 10, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Aaron Deitz</b>			DEGREE <b>MD</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <b>7-10-68</b>								
22d. PHYSICIAN'S NAME (Type) <b>Aaron Deitz</b>			22e. ADDRESS <b>Hyattsville, Md.</b>														
23a. BURIAL, CREMATION, REBURY (Type) <b>Reburied</b>			23b. DATE <b>July 13, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Mont., Md</b>								
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>						ADDRESS <b>Hyatts., Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JUL 12 1968</b>		25b. REGISTERING AGENCY <b>Johnston</b>			



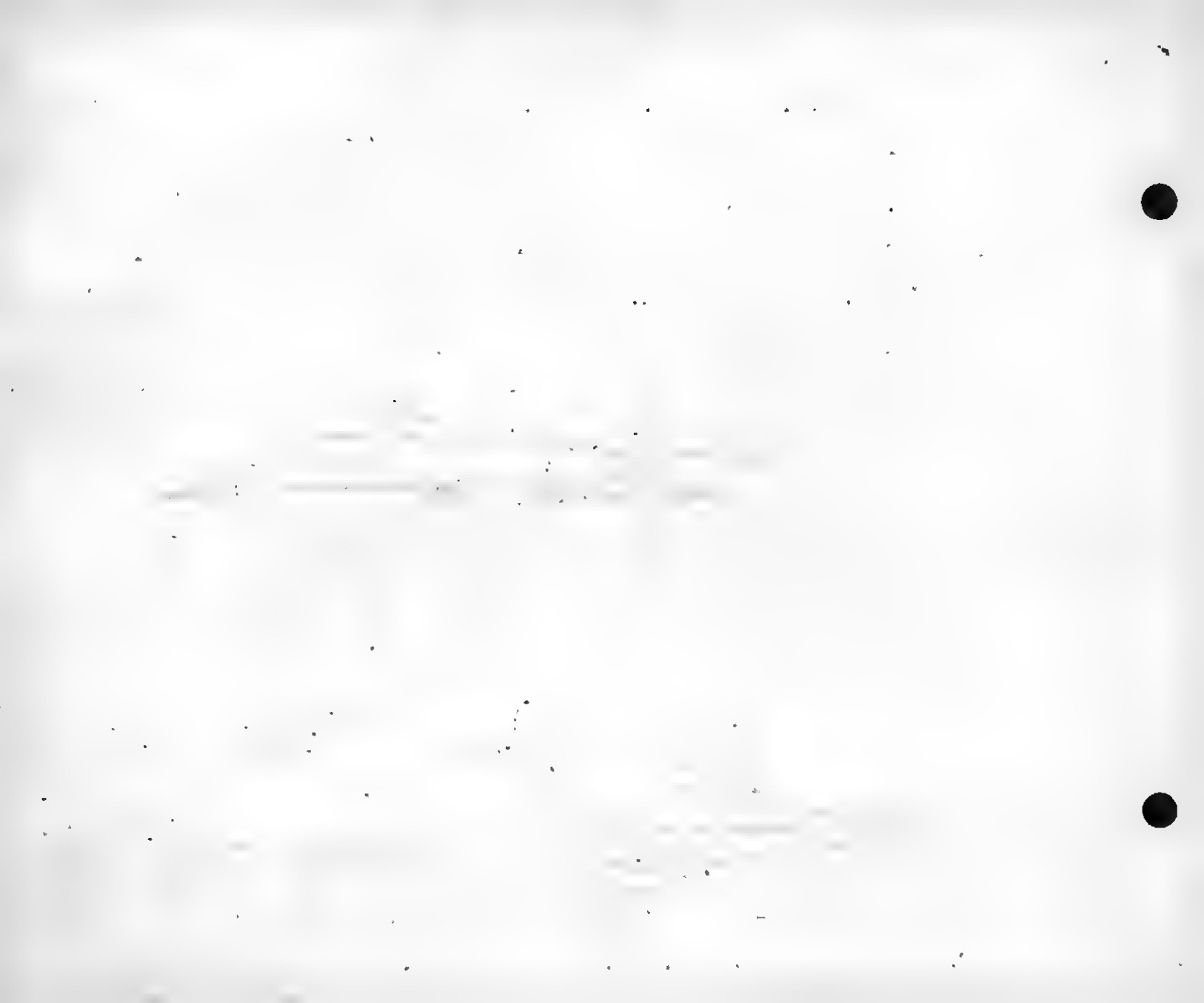


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) <b>William E. Thomas</b>			2a DATE OF DEATH Month <b>7</b> Day <b>8</b> Year <b>1968</b>			2b HOUR <b>11:20</b> AM	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>9/20/13</b>		6 AGE (in years last birthday) <b>54</b> YRS.	
7a BIRTHPLACE (State or foreign country) <b>Va.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md.	
10 CITY OR TOWN OF DEATH <b>Riverdale</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address) <b>Frederick Memorial Hospital</b>		12a USUAL OCCUPATION (Kind of work done, if not at work, state if retired) <b>Printing</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Dept of Arm</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>P. G.</b>		13c CITY OR TOWN <b>Carrollton</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First <b>Charles</b> Middle <b>Thomas</b> Last		15 MOTHER'S MAIDEN NAME First <b>Lillian</b> Middle <b>Leigh</b> Last					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown		16b SOCIAL SECURITY NO. <b>577-14-3754</b>		17 INFORMANT Address <b>Marie L. Thomas 6700 Belcrest Rd. Hyatts. Md.</b>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ac Myocardial Failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Metastatic Carcinoma of Lung</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital attended the deceased from <b>June 68</b> to <b>July 68</b> , that (I) (we) last saw the deceased alive on <b>June 19 68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>W. L. Etienne</b>		22c PHYSICIAN'S NAME (Type) <b>W. L. ETIENNE</b>		22d ADDRESS <b>College Park, Md.</b>		22e DATE SIGNED <b>7/8/68</b>	
23a. BURIAL, CREMATION, REINTERMENT <b>Burial</b>		23b DATE <b>7-11-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>George Washington Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Hyattsville, Md.</b>	
24 FUNERAL DIRECTOR <b>F. Gasch's Sons 4739 Balt. Ave. Hyattsville, Md.</b>				25a REC'D BY REGISTRAR <b>JUL 11 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) <b>JOHN ALLEN TRUPE</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTI <input type="checkbox"/> MATED <input type="checkbox"/> <b>July 7 1968</b>		2b. HOUR <b>1030 A.M.</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>Oct 30 1926</b>	6. AGE (In years last birthday) <b>41</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD <b>July 7 1968</b>		2d. HOUR <b>1030 A.M.</b>			
7a. BIRTHPLACE (State or foreign country) <b>Ohio USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>				Md	
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Eugene Leland Memorial</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Pr Geo</b>		13c. CITY OR TOWN <b>Brentwood</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>3808-37 Rd</b>			
14. FATHER'S NAME First <b>Charles H</b> Middle <b>Trupe</b> Last <b>Trupe</b>				15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>newmeyer</b> Last <b>newmeyer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes give way or branch of service) <b>WW2</b>		16b. SOCIAL SECURITY NO <b>282 229575</b>		17. INFORMANT <b>Wife Elizabeth Trupe</b>		ADDRESS <b>3808-37 Rd Brentwood Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Respiratory arrest due to General (Pneumonia)</b>											
DUE TO OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>General lesion gran for Bronchopneumonia few inches</b>											
DUE TO OR AS A CONSEQUENCE OF <b>Multiple de Pulmonary Abscesses at lung/organism</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION <b>7-7-68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Hemostatic - Multiple de Pulmonary abscesses</b>				20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>10 30 P.M. 7-7 19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Respiratory arrest during anesthesia</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Hospital</b>		21f. LOCATION Street or R.F.D. No <b>Eugene Leland Memorial</b>		City or Town <b>Riverdale</b>		County <b>Pr Geo</b>		State <b>Md</b>	
22a. I certify that I took charge of the remains described above. Held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dayton O Watkins</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>7-7-68</b>				22b. DATE SIGNED			
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>				ASS STANT MED CAL. EXAMINER <input type="checkbox"/> <b>5318 Annapolis Rd</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <b>Bladensburg Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>7-13-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trumbull Co. Off 10</b>		23d. LOCATION (City or Town) (County) (State) <b>Trumbull Co Ohio</b>					
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First <b>Eva</b> Middle <b>B.</b> Last <b>Vetter</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>6:55A</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>8/12/23</b>		6. AGE (in years last birthday) <b>44</b> YRS		7. IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>house wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Morningside</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>508 Allies Road</b>	
14. FATHER'S NAME First <b>Henry</b> Middle <b>Dennis</b> Last			15. MOTHER'S MAIDEN NAME First <b>Ocie</b> Middle <b>Garison</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Vera DaCrema, 5910 28 Avenue, Marlow Hts., Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Wide spread metastasis</b> DUE TO, AS A CONSEQUENCE OF (c) <b>Bronchogenic Ca.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>1621</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b> <b>Undetermined</b> <b>Undetermined</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Acute lobar pulmonale</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>7/20</b> , 19 <b>68</b> , to <b>July 22</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>July 22</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Faruk Ozer M.D.</b>		22c. DATE SIGNED <b>7/22/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Faruk Ozer</b>		22e. ADDRESS <b>Prince George's Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7-25-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>			
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> <b>4308 Suitland Rd. Suitland, Maryland</b>				25a. REC'D BY REGISTRAR <b>JUL 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115  
30M REV. 7-68

10558		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		70	
TEMP 9 Film 0452 11-13/68 vmp					
1. DECEASED-NAME (Type or print) First Middle Last Charles Stanley Walters			2a. DATE OF DEATH Month Day Year July 9 1968		2b. HOUR 11:25AM
3. SEX Male	4. RACE white	5. DATE OF BIRTH June 14, 1912		6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Chicago, Ill.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Prince George's Md.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 902 Elm Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painted interior oil	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Takoma Park	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 902 Elm Avenue
14. FATHER'S NAME First Middle Last John Henry Walters		15. MOTHER'S MAIDEN NAME First Middle Last Ella Mae Stanley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 000 11 214-24-1389	17. INFORMANT Michael S. Walters 4407 R. Mason Street, Baltimore, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Cerebral left lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos 5 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-14, 1967, to 7-9, 1968, that (I) (we) last saw the deceased alive on 7-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 11:25 am					
22b. SIGNATURE Joanne C. Bateman M.D.		DEGREE M.D.		22c. DATE SIGNED 7-10-68	
22d. PHYSICIAN'S NAME (Type) Joanne C. Bateman		22e. ADDRESS 312 So. Wash. St. Alexandria, Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
24. FUNERAL DIRECTOR Varner C. Humphrey, Inc.		ADDRESS 8434 Georgia Avenue Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE JUL 17 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1  
30M REV 1-68

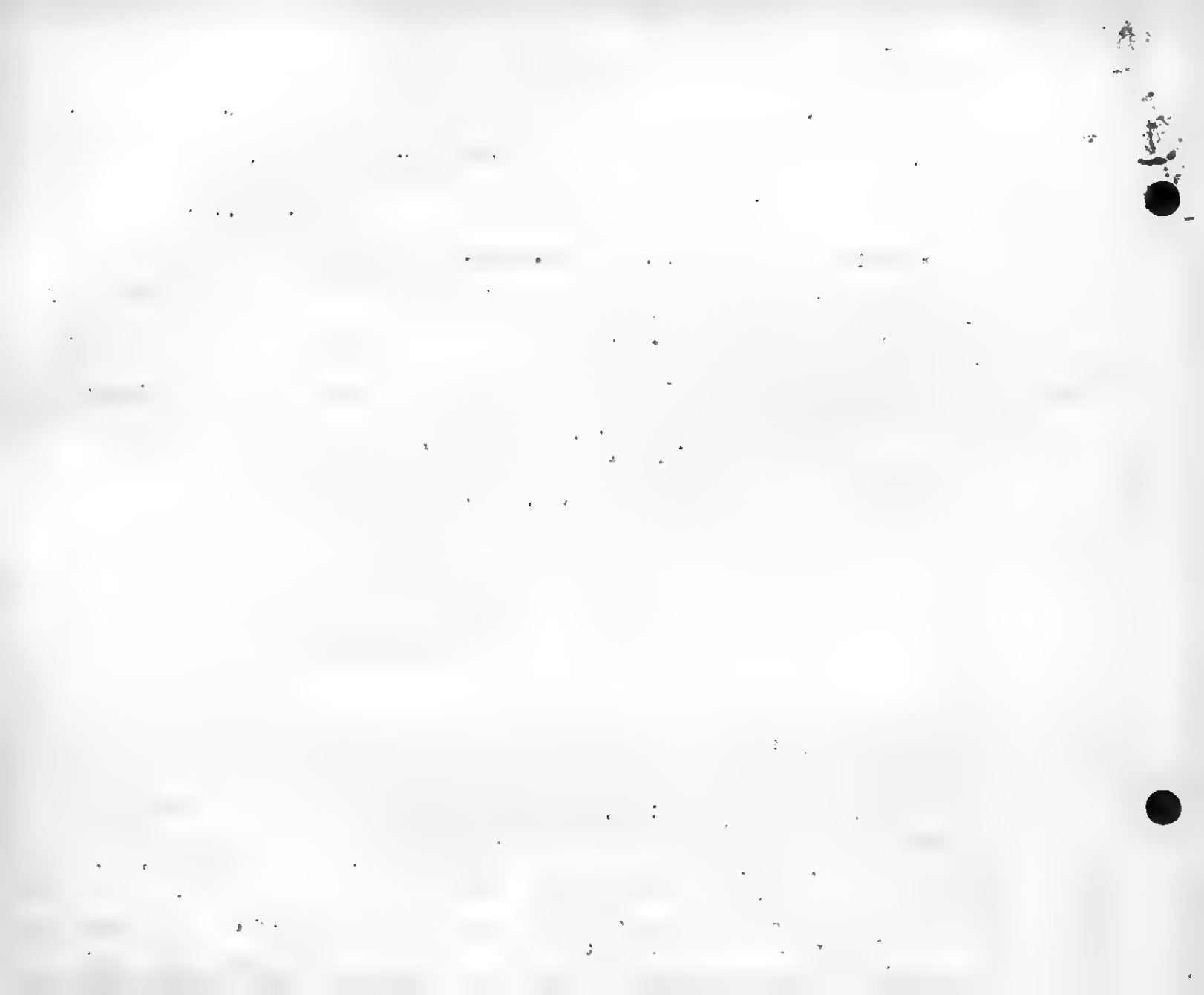
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

10559

10559

1. DECEASED NAME (Type or print) <b>James Wamsley</b>			2a. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1968</b>			2b. HOUR <b>3:10</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>11/1/07</b>		6. AGE (In years last birthday) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George</b> Md				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) <b>Restaurant Operator</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Geo</b>		13c. CITY OR TOWN <b>Mt Rainier</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>3123 Queens Chapel Road</b>	
14. FATHER'S NAME First <b>Walter</b> Middle <b>-</b> Last <b>Wamsley</b>			15. MOTHER'S MAIDEN NAME First <b>Fannie</b> Middle <b>-</b> Last <b>Duffey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>577 05 1979</b>		17. INFORMANT Address <b>Althea Blaylock 2412 36th St SE Wash DC</b>					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebellar Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED Where <input type="checkbox"/> Not where <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		State
22a. I certify that (I) (the hospital) attended the deceased from <b>July 2</b> , 19 <b>68</b> , to <b>July 6</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>July 6</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>O. Sahakyan</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <b>O. Sahakyan</b>						22e. ADDRESS <b>6001 Landover Rd., Cheverly, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>7-9-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Bladensburg PG Maryland</b>		
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road Suitland Maryland</b>						25a. REC'D BY REGISTRAR <b>JUL 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

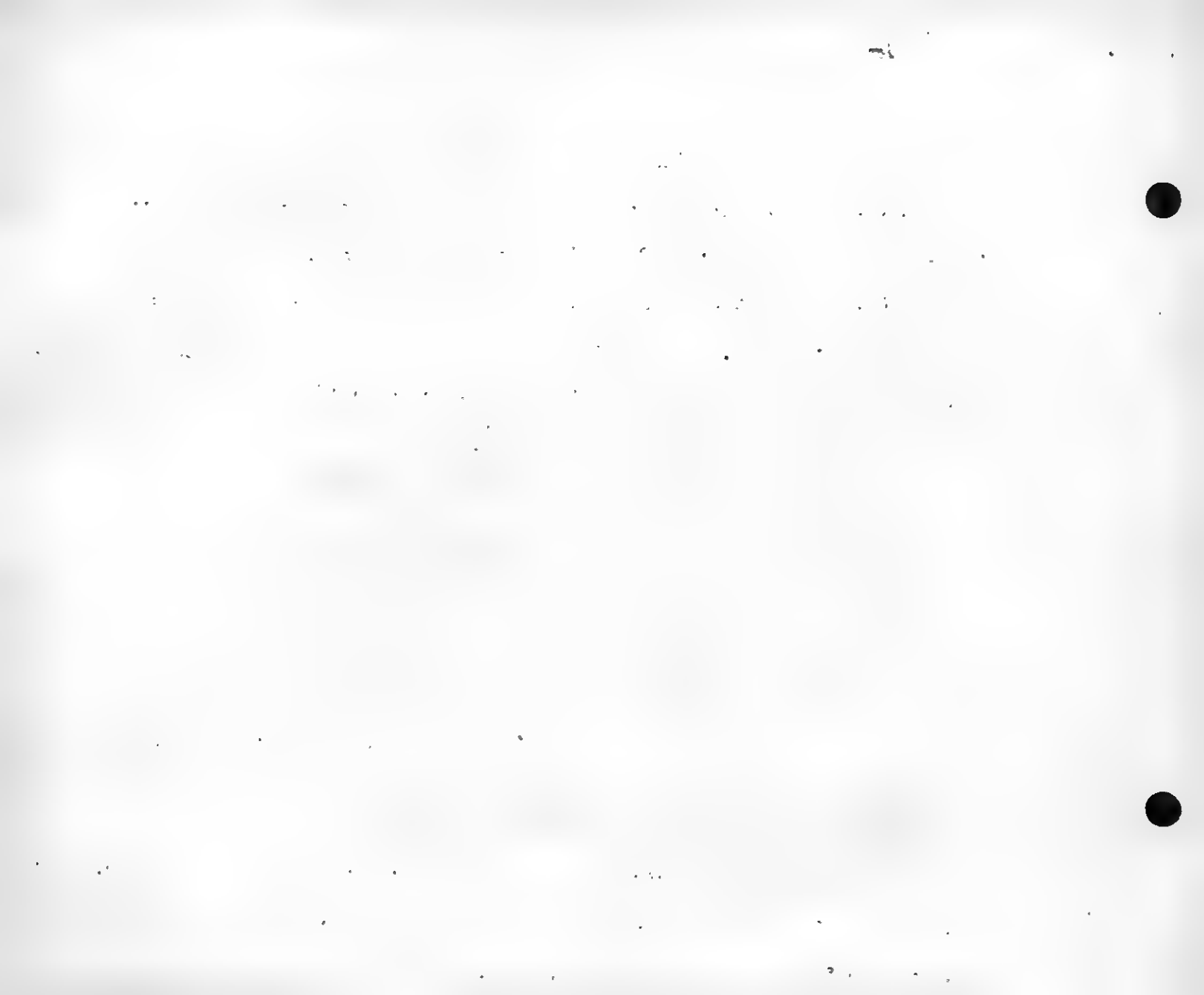
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) <b>Roger N. Wells</b>						2a. DATE OF DEATH Month <b>7</b> Day <b>3</b> Year <b>68</b>			2b. HOUR <b>4:38p</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-18-12</b>		6. AGE (In years last birthday) <b>55</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's County</b> Md						
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's General</b>				12a. USUAL OCCUPATION (Kind at work done during most of working life, even if retired.) <b>Electrician</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Brentwood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4102 Parkwood Street</b>		
14. FATHER'S NAME First Middle Last <b>James W. Wells</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Julia Elizabeth Nicholas</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>				16b. SOCIAL SECURITY NO. <b>579-03-0438</b>		17. INFORMANT Address <b>Daughter Sylvia Holtz Same as above</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinomatosis</b>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma / Lung</b>												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <b>163x</b>												
19a. DATE OF OPERATION <b>NA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>NA</b>		21b. TIME OF INJURY HOUR A.M. <b>NA</b> Month <b>NA</b> Day <b>NA</b> Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>NA</b>								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>NA</b>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC. <b>NA</b>		21f. LOCATION Street or R.F.D. No <b>NA</b> City or Town <b>NA</b> County <b>NA</b> State <b>NA</b>								
22a. I certify that (I) (this hospital) attended the deceased from <b>7/3</b> , 19 <b>68</b> , to <b>7/3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>7/3</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Barry Rosenberg M.D.</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <b>Barry Rosenberg, M.D.</b>						22e. ADDRESS <b>6501 Landover Road, Cheverly, Md. 20785</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodfield Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Galesville Maryland</b>						
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>						ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, may the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
George B. White						July 2, 1968		7:30A M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR	
Male		Caucasian		12/3/03		64 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		U.S.A.				Prince George's		Md	
1d. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USAL OCCUPATION (Kind of work done during most of work no life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Geo.Gen'l Hospital		FARMER		TOBACCO			
13a. U.S.A. RESIDENCE (Where deceased lived, if not in an residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince George's		Clinton				7635 Lohr Lane	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
LEE WHITE			NETTA PAYNE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
NO		220-05-7602		JUNE RIDDLE		CLINTON, MD.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Metastatic brain lesion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma of the prostate.</u>								APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>1771</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <u>May 20, 1968</u> , to <u>July 2, 1968</u> , that (X) (we) last saw the deceased alive on <u>July 2, 1968</u> , and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE SIGNED			
<i>Josefino Ceballos, M.D.</i>		Josefino Ceballos, M. D.		Prince George's General Hospital, Cheverly		July 2, 1968			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)		Maryland	
BURIAL		7-5-68		BELL'S METH CEM.		CAMP SPRINGS MD.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HUNTT FUNERAL HOME		WALDORF, MD.		JUL - 8 1968		<i>Charles Judge</i>			

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10562

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <b>First Thomas Middle Earl Last Thomas- White</b>				2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-14-68 199:25pm		2b HOUR	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>10-10-1946</b>	6 AGE (In years last birthday) <b>21 YRS</b>	F UNDER 1 YEAR MONTHS DAYS HOURS MIN	F UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 7 Day 14 Year 68 9:59pm	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CIT ZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 <del>MARRIED</del> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b> Md	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>2nd Class Petty Officer</b>		12b K ND OF BUSINESS OR INDUSTRY <b>U.S.Navy</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Prince George's</b>		13c CITY OR TOWN <b>Mitchelville</b>		13d INS DE CITY + MTS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET AND NUMBER <b>Rt. 2, Box 91-B</b>		14 FATHER'S NAME First Middle Last <b>Thomas A. White</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Ruth -- Catterton</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service)	
16b SOCIAL SECURITY NO <b>213-46-6604</b>		17 INFORMANT <b>Mrs. Ruth Catterton Richards</b>		ADDRESS <b>13-a-c.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> <b>129</b> DUE TO, OR AS A CONSEQUENCE OF <b>Skull fracture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>From trauma - auto accident</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>9:25pm 7-14-19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) <b>Driver of car involved in collision.</b>			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Queen Anne Road and Route # 214,</b>		21f. LOCATION Street or R.F.D. No City or Town County State <b>Pr.Geo Maryland</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>John Kehoe MD</b>		RIVERDALE, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED <b>7-15-68</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>7/18/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Methodist Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Lothian A.A. Md.</b>	
24 FUNERAL DIRECTOR <b>Ritchie Bros. Upper Marlboro, Md.</b>				25a REC'D BY REG STRAR DATE <b>JUL 24 1968</b>		25b REG STRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15  
30M REV 1968

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Walker Guy Willett						Month Day Year		5 30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		5-30-03		65 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Prince George Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Clinton			Pine View Gardens			Farmer		TOBACCO		
13a. USUAL RESIDENCE (Where deceased lived, if not last at residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince George		Accokeek		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 41	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
D Guy Willett			VIRGIE IRENE Pickerell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address		
No			212-10-3990			MRS. Walker Willett		Accokeek Md.		
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) 185X Cardiac Arrest										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Terminal CA with Metastases										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Prostatic CA										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
Diabetic										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 7-18, 1968, to 7-24, 1968, that (I) (we) last saw the deceased alive on 7-24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					22c. DATE SIGNED					
Alfred R. Lavin M.D.					7-24-68					
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
ALFRED R. LAVIN, M.D.					CLINTON, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		7-27-68		CHRIST CHURCH ACCOKEEK		PR. GEO. MD				
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hunt Funeral Home, Waldorf, Md.					JUL 29 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
10564		12049		CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR			
Fairice Victor			Willie			July 7 1968		1545			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS DAYS			
MALE		CAU		11 Aug. 1923		44 YRS.					
7a. BIRTH-PLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
ARK.		U.S.A.				PRINCE GEORGES Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
ANDREWS AFB			MALCOLM GROW USAF HOSP.			Hon. Com. Officer		MILITARY			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			PRINCE GEORGE		SUITLAND		YES		4628 HOME AVE		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Charles			Willie			Ann			Strickland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
YES			432-26-2489			Wife			Same as Above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC BLADDER TUMOR</u>									1 YEAR		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>											
(c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
FEB. 68		Metastatic tumor				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1 OCT</u> , 19 <u>67</u> , to <u>7 JULY</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>7 JULY</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d d) (do not) view the body after death											
22b. SIGNATURE <u>Dennis R. Derby</u>						22c. DATE SIGNED 7 JULY 68					
22d. PHYSICIAN'S NAME (Type) Dennis R. Derby Maj						22e. ADDRESS Malcolm Grow USAF Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
		7-9-68		Memorial Garden		Paragould Ark.					
24. FUNERAL DIRECTOR W. W. Chamber Co. 517-11th St. S.E.						25a. REC'D BY REGISTRAR SEP 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Joseph Kent Wilson</b>					2a. DATE OF DEATH Month <b>July</b> , Day <b>10</b> , Year <b>1968</b>		2b. HOUR <b>7:25</b> P <b>M</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>12/25/1900</b>		6. AGE (in years last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CIT ZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARR. <input checked="" type="checkbox"/> EVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Landover</b>		3a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8525 Sheriff Rd.</b>	
14. FATHER'S NAME First <b>Joseph Perry</b> Middle <b>Wilson</b> Last <b>Wilson</b>				15. MOTHER'S MAIDEN NAME First <b>Georgie</b> Middle <b>Wallis</b> Last <b>Wallis</b>					
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT <b>John N. Wilson</b> <b>8421 Sheriff Road Landover, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pulmonary Thrombo-embolii.</b> <b>4270</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart failure.</b> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Right subdural Hemorrhage.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) <del>(attending physician)</del> attended the deceased from <b>July 5, 1968</b> to <b>July 10, 1968</b> , that (I) <del>(my)</del> last saw the deceased alive on <b>July 10, 1968</b> , and that in (my) <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.									
22b. SIGNATURE <b>Don B. Cameron</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>July 11, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Don B. Cameron, M. D.</b>				22e. ADDRESS <b>3503 Perry St. Mt. Rainier, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>7/13/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		23d. LOCATION (City or Town) (County) (State) <b>Upper Marlboro P. G. Md.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



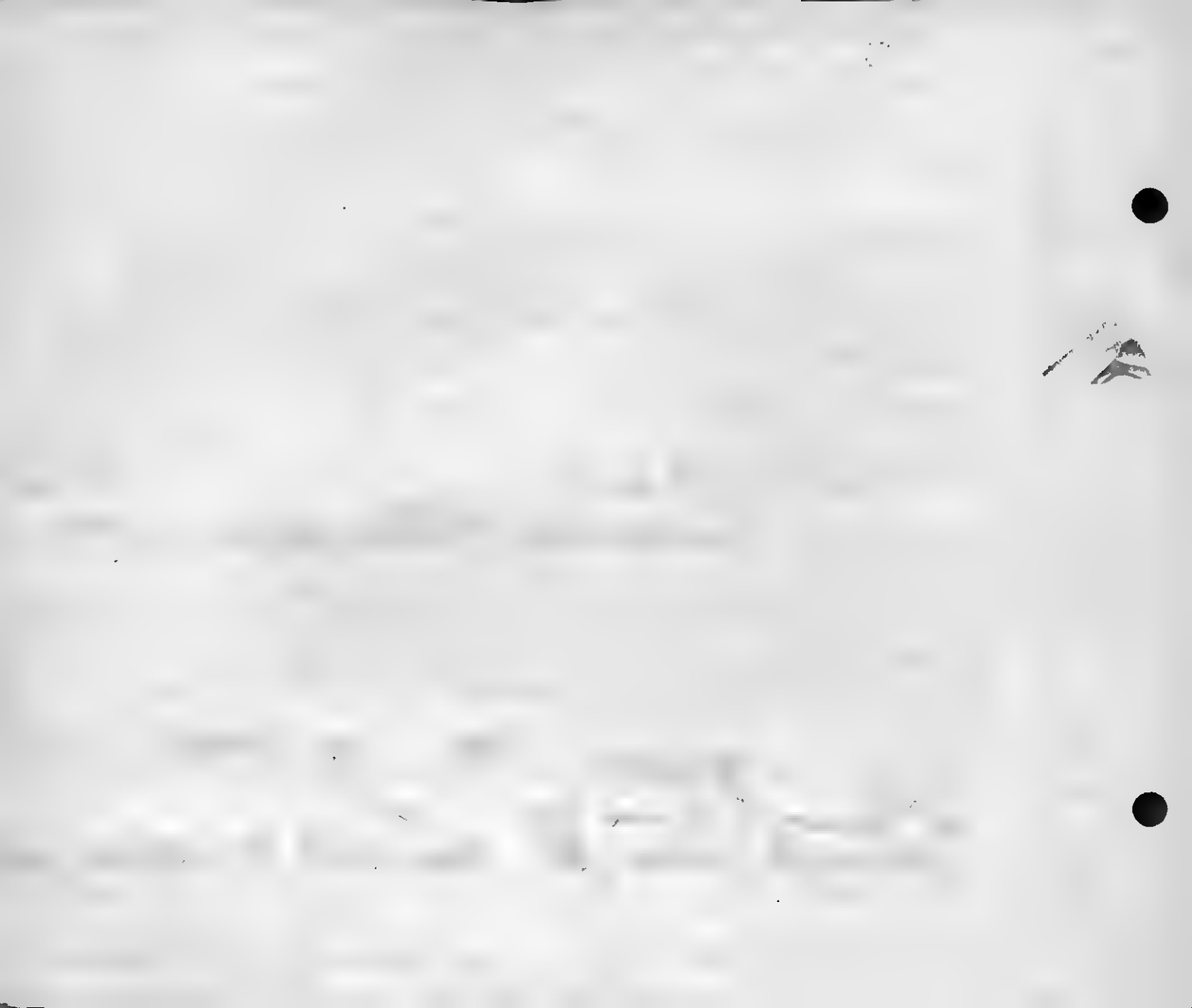
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10566

74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>R. Geo. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>R. Geo. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9920 Buena Vista Ave</u>		e. STREET ADDRESS <u>9920 Buena Vista Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E</u> Last <u>WINSTON</u>		4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1968</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 1874</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Winston</u>		14. MOTHER'S MAIDEN NAME <u>Mollie P</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>231 481599</u>	
17. INFORMANT <u>Rosie W. Baugh</u>		Address <u>9920 B.V. Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Jan 7/10/68</u> 19 <u>68</u> to <u>7/10/68</u> 19 <u>  </u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>7/10/68</u> and that death occurred at <u>  </u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>A. Henry G. Wise Jr.</u> M.D.		22b. DATE SIGNED <u>7/10/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u>		22d. ADDRESS <u>9005 Volta St Lanham, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7-13-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Co. Line Bap. Ch.</u>	23d. LOCATION (City, town or county) (State) <u>Hodensville Md.</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>H.S. Washington</u>		25a. REC'D BY REGISTRAR <u>15 1968</u>	
ADDRESS <u>4925 Drake Ave NE</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





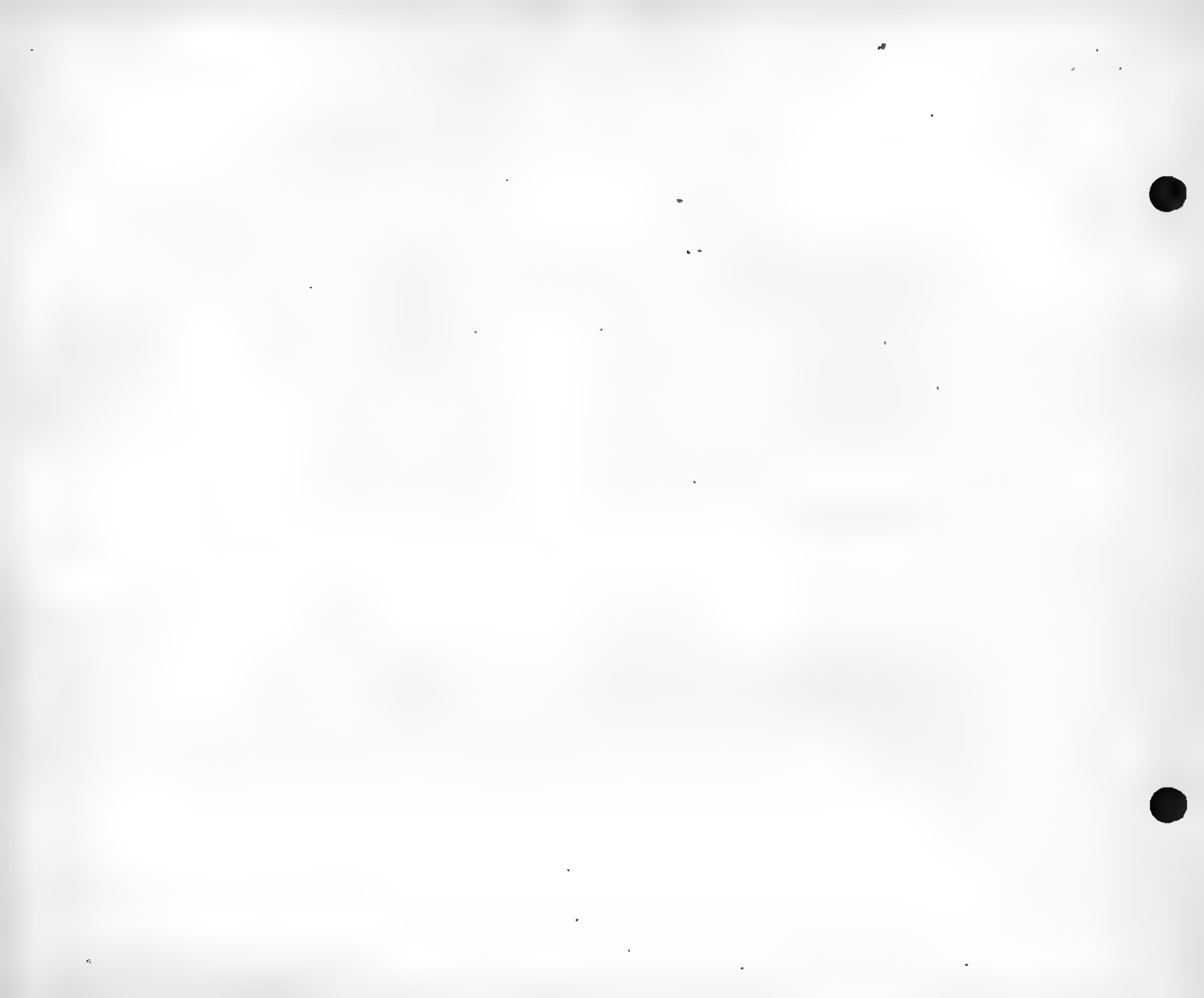
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI DEATH MATED		2b. HOUR	
ROY WASHINGTON WOLFE						July 2 1968		8:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. UNDER 1 YEAR MONTHS	8. UNDER 24 HRS HOURS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	W	April 13 1904	64 YRS			July 3 1968		7:00 AM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Prince Georges Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Georges General Hospital			Nurse Tender		Tugboat	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. STREET AND NUMBER				
MD			Prince Georges		1300 C - 68T				
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Edwin Foreman Wolfe			Helen Elizabeth Conway						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		
No					Sister Margaret Payne Bowie		1300 C - 68T		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis occlusion 410. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) of Right Coronary artery few miles DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4231									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
DAYTON O WATKINS			M.D.			7-36V			
EXAMINER'S NAME (Type)			DEPTLY MEDICAL EXAMINER <input checked="" type="checkbox"/>			5318 Annapolis Rd			
DAYTON O WATKINS			ADDRESS (Street, city, town, or county)			Bladensburg Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial	7-6-68	Glen Haven Memorial Park			Glen Burnie Md.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Don Will Donaldson			Lanham, Md			JUL - 9 1968		Charles Judge	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10568

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10576

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 7-14-68		2b. HOUR 18:30pm M
Frank		M		Wood Sr.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year
Male	White	7-3-1899		69 YRS.			7 14 68 19 8:47pm M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Virginia		U.S.A.				Prince George's Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital		CARPENTER		Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Prince George's		Beltsville		13e. STREET AND NUMBER 6821 Beaver Dam Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
JAMES		Wood		UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No				578-03-14215		MARIE B. BOYD 1009 CHillum Rd #315 HYATTSVILLE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 8 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1538</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED			
<u>John Kehoe</u>		John Kehoe MD Riverdale, Md.		7-15-68			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		7-18-68		Ft. Lincoln Cemetery		Wash. D.C.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. Chambers Co. Inc.		Riverdale, Md.		DATE JUL 18 1968		J Charles Judge	

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RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.  
20250  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C.  
20250  
MEMORANDUM FOR THE SECRETARY  
SUBJECT: [Illegible]  
DATE: [Illegible]  
FROM: [Illegible]  
TO: [Illegible]  
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a memorandum or report.]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or Print) <b>JOHN V YEAGER</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>July</b> Day <b>3</b> Year <b>1968</b>		2b. HOUR <b>M</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Sept 5 1898</b>		6. AGE (In years last birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD <b>July 3</b> Year <b>1968</b>		2d. HOUR <b>12</b> <b>00</b> <b>M</b>	
7a. BIRTHPLACE (State or foreign country) <b>DC</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Prince Georges</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges Gen Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Los Light</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Los Light</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>				13b. COUNTY <b>Pr Geo Mt Rainier</b>				13c. CITY OR TOWN <b>Yes</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE CITY LIMITS? <b>Yes</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3111 Window Rd</b>			
14. FATHER'S NAME First <b>John</b> Middle <b>V</b> Last <b>Yeager Sr</b>				15. MOTHER'S MAIDEN NAME First <b>Minnie</b> Middle <b>Zigler</b> Last <b>Zigler</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO <b>577 67731</b>				17. INFORMANT <b>Son, Ronald J Yeager</b>				ADDRESS <b>7741 Riverdale Rd New Carrollton Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF <b>few minutes</b> (b) <b>Coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>years</b> (c) <b></b>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b></b> P.M. <b></b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>Dayton O Watkins</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				5318 Annapolis Rd							
EXAMINER'S NAME (Type) <b>DAYTON O WATKINS</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>Bladensburg Md</b>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) <b>7-3-6</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>7-6-1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>Nalley Funeral Home Mt. Rainier, Md.</b>				ADDRESS <b></b>				25a. REC'D BY REGISTRAR <b>AUL - 8 1968</b>				25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			



*[Faint, illegible handwritten text covering the majority of the page]*

